L.E.

vs

LEE, et al.

MELISSA CYPERSKI, PH.D.

August 10, 2022

Deborah H. Honeycutt, LCR

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

L.E., by his next friends and parents, SHELLEY ESQUIVEL and MARIO ESQUIVEL,

Plaintiff,

vs. No.: 3:21-cv-00835

BILL LEE, in his official capacity as Governor of Tennessee, et al., Chief Judge Crenshaw

KNOX COUNTY BOARD OF EDUCATION a/k/a KNOX COUNTY SCHOOL DISTRICT; ROBERT M. "BOB" THOMAS, in his official capacity as Director of Knox County Schools, Magistrate Judge Newbern

Defendants.

Videoconference Deposition of:

MELISSA A. CYPERSKI, Ph.D.

Taken on behalf of the Defendants
August 10, 2022

Commencing at 9:37 a.m.

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I N D E X

E X H I B I T S

E X H I B I T S

S T I P U L A T I O N S

The videoconference deposition of MELISSA A. CYPERSKI, Ph.D. was taken by counsel for the Defendants, by Notice, with all participants appearing at their respective locations, on August 10, 2022, for all purposes under the Tennessee Rules of Civil Procedure.

All objections, except as to the form of the question, are reserved to the hearing, and said deposition may be read and used in evidence in said cause of action in any trial thereon or any proceeding herein.

It is agreed that Deborah H. Honeycutt, Notary Public and Licensed Court Reporter for the State of Tennessee, may swear the witness remotely, and that the reading and signing of the completed deposition by the witness is not waived.

* * *

THE REPORTER: Good morning. My name is Deborah Honeycutt. I am a stenographic reporter with Elite-Brentwood Reporting Services. My license number is 472.

Today's date is August 10, 2022, and the time is approximately 9:37 a.m. Central time.

This is the deposition of Melissa A. Cyperski, Ph.D. in the matter of L.E. by his next friends and parents, Shelley Esquivel and Mario Esquivel vs. Bill Lee, Governor of Tennessee, et al., filed in the United States District Court for the Middle District of Tennessee, Nashville Division. The Case Number is 3:21-cv-00835. This deposition is being taken by videoconference, and the oath will be administered remotely by me.

At this time, I'll ask counsel to identify yourselves and state whom you represent. If you have any objections with the procedures I've outlined, please state so when you introduce yourself. We will start with the noticing attorney.

MR. HILDABRAND: This is Clark Hildabrand. I am representing the State Defendants in this case, along with Travis Royer is here right

now, and Stephanie Bergmeyer will be joining later in the deposition.

MS. BROWN: Again, Taylor Brown from the American Civil Liberties Union for Plaintiff.

MS. BORELLI: This is Tara Borelli with Lambda Legal for the plaintiff.

MS. BROWN: We also have with us Cameron Vaughn for Plaintiff from the ACLU of Tennessee. And then we also have -- Britany, do you want to introduce yourself?

MS. RILEY-SWANBECK: Yes. This is Britany Riley-Swanbeck from Wilmer Hale.

MR. SANDERS: And this is David Sanders representing Knox County Board of Ed. and Dr. Jon Rysewyk.

* * *

MELISSA A. CYPERSKI, Ph.D.,

was called as a witness, and after having been duly sworn, testified as follows:

EXAMINATION

QUESTIONS BY MR. HILDABRAND:

Q. All right. Thank you for coming to testify today. As we just said, my name is Clark

Hildabrand. I'm one of the attorneys for the State of Tennessee. Just for the record, could you say and spell your last name?

A. Good morning. My name is Melissa Cyperski. C-Y-P-E-R-S-K-I.

Q. Thank you. Before we get underway, I just want to lay out some ground rules. If I cut you off too early, just let me know and I'll let you finish your answer. Similarly, just try to let me finish my answer as well -- sorry -- finish my question as well before you answer. The attorneys there would also appreciate if you give them a second to give them a chance to object if they need to. But unless they instruct you not to answer because of attorney-client privilege, after they object you should answer the question. Is that good with you?

A. Yes.

Q. And since we're trying to create a clear transcript, I'd appreciate it if you could answer with a clear verbal response rather than just shaking your head yes or no like we do in a conversation if we were just having conversation back and forth. Does that make sense?

A. Yes.

Q. And unless you tell me you don't understand

the question, is it fair to assume you understood the question and answered to the best of your ability?

A. Yes.

Q. If you need to take a break at any point, let us know. We'll try to take breaks every once in a while, maybe once an hour, and also break for lunch at some point.

And just to establish the validity of the deposition, there's no reason you would be impaired today or unable to give truthful testimony, such as for taking medication or something like that?

A. There is not.

Q. Thank you. Did you review anything to refresh your recollection in preparation for this deposition?

A. I reviewed my report.

Q. Anything else?

A. Not that I recall.

Q. Did you have discussions with anyone in preparation for today's deposition?

A. I had discussions with counsel.

Q. When were those discussions?

A. Over the past week we met on several occasions.

Q. Thank you. And you cited in the report every authority that you relied upon in drafting your report, correct?
A. Yes.
MR. HILDABRAND: So I'll start by entering what we have as Doc A. We'll have this as Exhibit 1.
Travis, can you circulate that around. You should see in chat there's a Document A, Cyperski report. We're going to enter that as Exhibit 1.
(WHEREUPON, a document was marked as Exhibit Number 1.)
BY MR. HILDABRAND:
Q. Thank you. Dr. Cyperski, can you see that document?
A. Yes, I can.
Q. Is this your expert report?
A. Yes.
Q. Thank you. So we're going to look at this a little bit. On page one, paragraph three, do you see where that is?
A. Yes.
Q. So here do you say that you reviewed the text of Senate Bill 228 at issue in this matter?

A. Yes.
Q. Just to confirm, you are not an attorney, correct?
A. That is correct.
Q. So you're not offering an expert legal opinion on the meaning of the law, correct?
A. That is correct.
Q. Later in paragraph three you say that you relied on professional guidelines and scientific literature in the pertinent fields. Is the pertinent field for you psychology?
A. Yes.
Q. And you are testifying as an offered expert in psychology; is that correct?
MS. BROWN: Objection.
THE WITNESS: So my expert report is around gender identity and including the guidelines. And considering gender dysphoria my expertise is as a mental health professional and psychologist.
BY MR. HILDABRAND:
Q. A medical professional and psychologist. Can you be more specific? What as a medical professional? Are you a psychiatrist?
A. I am sorry. I believe I said a mental health professional --

Q. Okay.
A. -- in which I am a psychologist.
Q. So you're not offering an expert opinion in psychiatry?
A. That is correct.
Q. What is the difference between psychology and psychiatry?
A. So psychologists tend to rely on more talk therapy and in reviewing literature and research related to mental health broadly. Psychiatrists in practice are specifically MDs and focus on prescription of medication to treat psychiatric conditions.
Q. And you mentioned the guidelines. Are you an expert in the WPATH Standards of Care?
A. I rely on these guidelines in my work.
Q. Thank you. And would other psychologists look to the most recent WPATH Standards of Care as well?
MS. BROWN: Objection.
THE WITNESS: I'm sorry, can you repeat the question?
BY MR. HILDABRAND:
Q. Do psychologists rely upon the WPATH Standards of Care?

A. At this time, WPATH Standards of Care are professional guidelines for mental health professionals and medical professionals that are specializing in working with individuals from the transgender community and who experience gender dysphoria.
Q. Do you rely upon the most current WPATH Standards of Care in your practice?
A. I do.
Q. And you joined WPATH last year, 2021, correct?
A. I believe that's correct, yes.
Q. Let's go to I think it's page 12 in the PDF. Page two in the CV. Do you see?
MS. BROWN: Sorry. Clark, if you'll give me one second, we're still scrolling.
MR. HILDABRAND: Of course. No problem.
MS. BROWN: Okay. We're on page two. Where would you like her to look?
BY MR. HILDABRAND:
Q. Do you see where it says professional organizations?
A. Yes.
Q. Does it list your membership in WPATH?
A. It does.

Q. When is the start date?
A. It lists 2021.
Q. Through present, correct?
A. Correct.
Q. Thank you. So let's take a step back and talk about your education. So this is going to be on page 11 of the PDF, page one of the CV, if y'all could scroll there.
MS. BROWN: Okay.
BY MR. HILDABRAND:
Q. Where did you go to college?
A. I attended Danville University, Granville, Ohio.
Q. What did you major in there?
A. I majored in psychology.
Q. And then where did you earn your M.S. degree?
A. I earned my Master's at Auburn University in Auburn, Alabama.
Q. So just curious, working at Vandy, are you more of a War Eagle or a Commodore, or are you really not much a sports person?
A. My heart would be in the Southeastern Conference with Auburn.
Q. Fair enough. I see here you wrote a thesis at Auburn for your M.S.; is that correct?

A. That is correct.
Q. Was that thesis required to earn your M.S.?
A. Yes.
Q. Did professors review and approve your thesis?
A. Yes.
Q. Then you received your Ph.D. in clinical psychology from Auburn as well; is that correct?
A. That is correct.
Q. What was your thesis on for your Ph.D.?
A. My dissertation for my Ph.D. was looking at the therapeutic alliances across the milieu. And these would be implications and challenges working with adjudicated adolescent males in residential treatment.
Q. Okay. Thank you. During your education at Tennessee University, did you receive education in transgender psychology?
MS. BROWN: Objection to form.
THE WITNESS: So I received my education at Auburn University.
BY MR. HILDABRAND:
Q. Yes. During your undergrad -- while receiving your undergraduate degree, your B.S. in psychology at Denison University, did you receive

any education there in transgender psychology?

MS. BROWN: Same objection.

THE WITNESS: I do not recall the specifics of my coursework at Denison. But I do not recall specifically learning about transgender psychology.

BY MR. HILDABRAND:

Q. While receiving your M.S. and Ph.D. at Auburn, did you receive education in transgender psychology?

MS. BROWN: Objection to form.

THE WITNESS: So in my doctoral study at Auburn University, part of the curriculum, including a semester-long course, was focused on clinical competencies with diverse populations on cultural considerations, which would include professions and content related to the LGBTQ+ community and the transgender community.

BY MR. HILDABRAND:

Q. Is what you learned there consistent with your report in this case?

A. So my understanding and professional expertise that was utilized to draft the report has been developed over time, including through continuing education and professional experience

post-graduation.
Q. And you received your Ph.D. in 2016; is that correct?
A. Yes, that is correct.
Q. How many years ago was that?
A. I believe it was seven years ago.
Q. So 2016 was seven years ago from now?
A. If my math is correct, yes.
Q. And while working toward your Ph.D., did you have pre-doctoral internship at Vanderbilt?
A. That is correct.
Q. Did you also have a doctoral fellowship at Vanderbilt University Medical Center?
A. Yes.
Q. And that's where you work today, correct?
A. Correct.
Q. Thank you. I know some of these questions are basic but we just have to get out of the way. And have you worked at the Vanderbilt Pediatric and Adolescent Transgender Health Clinic since the clinic opened in 2018?
A. That is correct.
Q. Is that clinic referred to as the acronym VPATH?
A. Yes.

Q. So VPATH sounds similar to WPATH. Does VPATH follow WPATH's approach to transgender medicine?

MS. BROWN: Objection to form.

THE WITNESS: So we are an interdisciplinary clinic that relies on multiple standards of care, including the WPATH Standards of Care and the Endocrine Society.

BY MR. HILDABRAND:

Q. Do the WPATH Standards of Care and the Endocrine Society Guidelines conflict?

MS. BROWN: Objection to form.

THE WITNESS: Those guidelines from the Endocrine Society and the WPATH are long documents. They are often in agreement with one another but may have points in which there is conflicting information within the hundreds of pages that are present.

BY MR. HILDABRAND:

Q. If there is a conflicting recommendation between the WPATH Standards of Care and the Endocrine Guidelines, is there one or the other that you would prefer?

MS. BROWN: Objection to form.

THE WITNESS: My experience is that it would be up to the treatment team and the particular

specialist that was making a decision about care which guidelines they would refer to specifically and rely on more.

MS. BROWN: Clark, I have a quick question, so I don't mean to interrupt. Do you want us to still be looking at the exhibit? Because when we are looking at it, it's taking up the whole screen, so we're not the seeing the Zoom. I'm just flagging that for you.

MR. HILDABRAND: You don't have to keep looking at it if you don't want to right now. But we'll return to it in just a second. So we'll leave it up there.

MS. BROWN: So leave it up.

BY MR. HILDABRAND:

Q. You mentioned that the provider would choose between the two of those. Is that up to their discretion to decide which is appropriate?

MS. BROWN: Objection to form.

THE WITNESS: The provider would rely on their expertise and scientific knowledge, as well as that assessment and collaboration with the patient and their guardian to determine an appropriate treatment plan and review of the guidelines.

/ /

BY MR. HILDABRAND:
Q. Do you provide service at VPATH inconsistent with both WPATH and the Endocrine Guidelines?
MS. BROWN: Objection to form.
THE WITNESS: I just want to make sure I heard the question correctly. Did you say consistent or inconsistent? Could you repeat, please?
BY MR. HILDABRAND:
Q. So we have discussed situations where there might be conflict or tension between the two. Would there be any scenario where you would provide service to the patient that would be inconsistent with both the Endocrine Guidelines and the WPATH Standards of Care?
MS. BROWN: Same objection.
THE WITNESS: We rely on the Endocrine Society Guidelines and the WPATH Guidelines to inform our practice. Treatment is individualized to meet the needs of each individual patient and their caregiver.
BY MR. HILDABRAND:
Q. Could it be individualized not to follow either the Endocrine Guidelines or the WPATH Standards of Care?

MS. BROWN: Objection to form.
THE WITNESS: Not that I'm aware of.
BY MR. HILDABRAND:
Q. Thank you. So turning back to the report, we're going to go up to the bottom of page two, top of page three. This is paragraph eight.
A. We are scrolling.
Q. Thank you.
MS. BROWN: Can you see that?
THE WITNESS: Yes. We are at the bottom of page two.
BY MR. HILDABRAND:
Q. All right. At the top of page three, do you see where it says: VPATH is an interdisciplinary clinic bringing together practitioners from endocrinology, psychology, primary care, and other fields provide comprehensive care to transgender children, adolescents, and their families; is that correct?
A. Yes.
Q. Just for the record, you are not an endocrinologist, correct?
A. I am not an endocrinologist.
Q. And you are not a primary care doctor, correct?

A. I am not a primary care physician.
Q. So you are not offering expert testimony about endocrinology?
MS. BROWN: Objection to form.
THE WITNESS: I am offering expert testimony around my role and experience as a psychologist and mental health professional. A part of that work, particularly in the VPATH Clinic, we collaborate very closely with our interdisciplinary team of providers, including endocrinologists, primary care physicians, and other providers as well.
BY MR. HILDABRAND:
Q. I understand that you may collaborate with them, but you are not an endocrinologist, correct?
A. I am not an endocrinologist, no.
Q. So do you offer an expert opinion about endocrinology? Yes or no?
A. I do not offer an expert opinion about endocrinology, although there may be some aspects of endocrinology practice that are represented in the Endocrine Society Guidelines or the WPATH that are pertinent to my practice as a mental health professional.
Q. And as we mentioned, you are not a primary

care physician. Are you offering expert testimony as a primary care physician?
A. No, I am not.
Q. Thank you. So turning down to -- back down to page 17 of the PDF. This is page seven of the CV.
A. We are on page seven of the CV.
Q. Does this list community and professional education activities?
A. Yes. These are community and professional education activities which are coursework primarily that I have provided to other professionals.
Q. I see did you provide information to the Tennessee Department of Children's Services otherwise called DCS?
A. Yes.
Q. When was that?
A. In my role at Vanderbilt University Medical Center, I have partnered closely with the Department of Children's Services since starting my pre-doctoral internship in 2016.
Q. And I see the dates for the Child Protective Services Supervisor Academy. Was that from 2020 to 2021?
A. Yes.

Q. But then also the Child Protective Services Academy was 2015 to 2020; is that correct?
A. That is correct.
Q. So in providing this guidance to CPS, are you using the same sort of psychological expertise that you're using to testify in this case?
MS. BROWN: Objection to form.
THE WITNESS: In my work with the Department of Children's Services, I rely on my professional expertise working in trauma influence care and as a licensed clinical psychologist with expertise in child and adolescent psychology.
BY MR. HILDABRAND:
Q. So you use your expertise as a psychologist and mental health provider?
A. Yes.
Q. Have you given presentations to the Tennessee Department of Children's Services?
A. Yes, I have.
Q. Do you still give presentations to DCS?
A. I do.
Q. When was the last presentation you remember giving to DCS?
A. I believe my last presentation with the Department of Children's Services was in May or June

of this year.
Q. Thank you. So going back up in your report to page one, paragraph two, so all the way back in the beginning. Are y'all there?
A. Almost.
MS. BROWN: We'll let you know when we're there.
BY MR. HILDABRAND:
Q. Thank you.
A. We are on page one of the report.
Q. Thank you. So do you see where it says you've been asked to provide your expert opinion on gender identity, gender dysphoria in children, adolescents, the treatment of gender dysphoria, and the impact of laws like Senate Bill 228, Tennessee's legislative ban on transgender middle and high school students for participating on interscholastic sports teams consistent with your gender; is that what you said there?
A. It is.
Q. Are those the subjects you opine on in your expert report?
A. They are.
Q. No other topics?
MS. BROWN: Objection to form.

THE WITNESS: Those are the topics that I addressed through my expert report.
BY MR. HILDABRAND:
Q. And just to go back on to expertise, you're also not a sports physiologist, correct?
A. I am not a sports physiologist, no.
Q. You are not an expert in exercise science, correct?
A. I am not.
Q. So turning to page three in the report, paragraph 13?
A. We're there.
Q. Thank you. So you say here: At birth, most people are assigned a sex, typically male or female based solely on the appearance of their external genitalia; is that correct?
A. Yes.
Q. And you did not offer an alternative definition of sex in your report, correct?
MS. BROWN: Objection to form.
THE WITNESS: This statement reflects that people are assigned a sex at birth typically based on the appearance of their external genitalia.
BY MR. HILDABRAND:
Q. Do you provide a definition of sex other than

this one here in your report?

MS. BROWN: Objection to form.

THE WITNESS: I do not offer a definition of sex in the report outside of this, although there are other understandings and can provide additional information about a definition.

BY MR. HILDABRAND:

Q. But you did not mention other understandings of sex in your report, correct?

MS. BROWN: Same objection.

BY MR. HILDABRAND:

Q. And feel free to look through your report and point me to somewhere if you did.

A. Not that I am aware of.

MS. BROWN: Do you want to take a moment to go through it?

THE WITNESS: I'm happy to take a moment to look through just in case.

MS. BROWN: Clark, we'll let you know. We are going to scroll and come back and then she'll answer your question. Okay.

BY MR. HILDABRAND:

Q. Thank you.

A. So we finished reviewing the document and there are references to sex assigned at birth, which

is what my field primarily uses to discuss an individual's sex assigned at birth. So the definition of sex may be more complicated and nuanced than that, particularly within the medical community.

Q. Just for the benefit of the transcript, you spent the past several minutes reviewing your expert report, correct?

A. That is correct.

Q. And you cannot point me to any page in your expert report where you provide a more complex or complicated definition of sex other than sex assigned at birth, correct?

MS. BROWN: Objection to form.

THE WITNESS: Although there may not be a more complex definition in the body of the report, professional experience would suggest and happy to provide more information about the complications and nuances of the definition of sex.

BY MR. HILDABRAND:

Q. Even if that's the case, you did provide a more complex definition of sex in the report, correct?

MS. BROWN: Objection to form.

THE WITNESS: In my report primarily

referring to sex assigned at birth and the concept of being assigned a sex at birth.

BY MR. HILDABRAND:

Q. You say primarily. Is there anywhere else that you refer to sex other than sex assigned at birth? Yes or no?

MS. BROWN: Objection to form.

THE WITNESS: The convention in the field is to refer to sex assigned at birth.

BY MR. HILDABRAND:

Q. So, sorry. I need you to answer the question. Did you use a definition of sex other than sex assigned at birth in your expert report? Yes or no?

MS. BROWN: Objection to form.

THE WITNESS: I used terminology consistent with sex assigned at birth.

BY MR. HILDABRAND:

Q. Did you use any other terminology in your expert report that you spent several minutes reviewing?

MS. BROWN: Same objection.

THE WITNESS: No.

BY MR. HILDABRAND:

Q. Thank you. In your expert report, did you

use the words "biology" or "biological"? And, again, feel free if you need to take a few minutes to review your expert report.

A. Yes. We'll need to take a few minutes.

Q. Of course.

MS. BROWN: And just let me know when you'd like me to scroll.

THE WITNESS: Okay. Scroll. You can scroll further. Can you scroll down. Scroll down. Please scroll down. Okay. You can scroll.

BY MR. HILDABRAND:

Q. Have you reviewed your report, or are you still looking over?

MS. BROWN: Again, Clark, we'll let you know when we have finished reviewing it. You gave her the offer to review it for the specific words that you mentioned and that's what we're doing. Okay?

BY MR. HILDABRAND:

Q. That's perfectly fine. I didn't know if I had missed you saying you were finished, so take as much time as you need.

A. Thank you. Scroll down. Okay. You can scroll. Go to the next page. Okay. You can scroll. You can scroll. You can scroll.

MS. BROWN: Okay. We reviewed.
THE WITNESS: Can you repeat the question for me?
BY MR. HILDABRAND:
Q. Do you do not use the words "biological" or "biology" anywhere in your expert report, correct?
MS. BROWN: Objection to form.
THE WITNESS: I do not appear to use the word "biology", though aspects of biology are represented in the report.
BY MR. HILDABRAND:
Q. And you did not use the word -- just for the record, you did not use the word "biological" either, correct?
MS. BROWN: Same objection.
THE WITNESS: Same as previous answer. The word "biological" is not captured but aspects of biology or biological consideration are discussed.
BY MR. HILDABRAND:
Q. Thank you. So getting back to sex assigned at birth, is sex assigned at birth or identified at birth?
MS. BROWN: Object to the form.
THE WITNESS: The terminology we use in the field is sex assigned at birth or sometimes sex

designated at birth.
BY MR. HILDABRAND:
Q. And who makes that assignment?
A. Typically sex is assigned by the physician and medical team delivering a baby.
Q. If there's no physician when the baby is delivered, which I know nowadays people deliver most babies in hospitals, but imagine you're in a situation where there's no doctor present when the baby is born. When the baby is born, before anyone has said a word, does the baby already have a sex?
MS. BROWN: Objection to form.
THE WITNESS: An individual sex can be determined by many different factors. It is often based on the appearance of external genitalia which may be visible in some cases at birth.
BY MR. HILDABRAND:
Q. To get back to the question, before anyone in the room says a word to say what the baby's sex is, does the baby already have a sex?
MS. BROWN: Same objection.
THE WITNESS: At birth a baby has aspects of their sex. However, their sex in this context and by definition is assigned at birth.
/ /

BY MR. HILDABRAND:

Q. So if a baby born has XY chromosomes, has a penis, has no disorder of sexual development, is born, before any doctor says a word what is the sex of that baby?

MS. BROWN: Objection to form.

THE WITNESS: So from that scenario it's hard to give an answer because, for example, many individuals with a disorder of sexual development or a DSD would not be available and/or detected at birth. So sex may be assigned at birth based on the appearance of the child's external genitalia.

BY MR. HILDABRAND:

Q. In the question I said a baby who does not have a DSD, a baby who is born with XY chromosomes, has a penis, has no DSD, they are born, they are sitting there, no doctor, the mother, the father, no one has said a word, does the baby already have a sex?

MS. BROWN: Objection to form.

THE WITNESS: I'm sorry, I have to reject the question because a DSD would often be determined later in life. It would not necessarily be detectable at birth.

/ /

BY MR. HILDABRAND:
Q. So rather than fighting the hypothetical, assume that later in life the baby is determined not to have a DSD, even back then when the baby was born, did the baby have a sex before anyone said a word?
MS. BROWN: Same objection.
THE WITNESS: The baby has aspects of sex that might include their biology of gametes and chromosomes and genitalia.
(Court Reporter interrupts for clarification.)
THE WITNESS: Thank you, Ms. Honeycutt. So they have aspects of biology, such as their gametes, their chromosomes, their genitalia, their hormones. Those are present in every individual and a sex is assigned at birth.
BY MR. HILDABRAND:
Q. But is it your position that the baby does not have a sex until it is assigned after birth?
MS. BROWN: Objection to form.
THE WITNESS: The consensus in the field is that a sex is assigned at birth.
BY MR. HILDABRAND:
Q. And that the baby does not have a sex until

it is assigned at birth?
A. In our experience and the way that we conceptualize cases, yes, sex is assigned at birth.
Q. And to return to the question, so there is no sex until it is assigned at birth?
MS. BROWN: Objection to form.
THE WITNESS: Sex is assigned at birth.
BY MR. HILDABRAND:
Q. Can you please answer the question yes or no. Is there a sex before it is assigned at birth?
A. It's very hard to answer as a yes or no because sex is a construct made of many different factors and is considered based on many different aspects of a person's biology and sex itself is a construct.
BY MR. HILDABRAND:
Q. So you cannot say that a baby has a sex before it is assigned at birth; is that correct?
MS. BROWN: Objection to form.
THE WITNESS: My opinion is that a sex is assigned at birth.
BY MR. HILDABRAND:
Q. When the child is in the womb does it have a sex?
MS. BROWN: Objection to form.

THE WITNESS: In the womb a sex may be assigned based on review of, for example, a child's external genitalia.

BY MR. HILDABRAND:

Q. And that would be before birth, correct?

A. So those individuals who received prenatal care, yes, that would be before birth.

Q. So is your definition of sex really sex is assigned at birth or sex is assigned when the child is in the womb?

MS. BROWN: Objection to form.

THE WITNESS: Sex is assigned at birth and represented on legal documents such as a birth certificate.

BY MR. HILDABRAND:

Q. So if the doctor sees -- performs an ultrasound -- sorry. First of all, does Vanderbilt University Medical Center provide ultrasounds to pregnant mothers?

MS. BROWN: Objection to form.

THE WITNESS: I'm here to represent my practice. And my professional opinion, it is likely that Vanderbilt University Medical Center does indeed perform ultrasounds on pregnant mothers, yes.

/ /

BY MR. HILDABRAND:
Q. So during an ultrasound, say that the mother is 20 weeks pregnant with the baby -- I'm sorry. Let's say 24 weeks pregnant with the baby. And the doctor sees in the ultrasound that the baby has a penis. They don't see any signs of a DSD being present, and they say that the baby is a boy. Is that accurate to say at that time that the sex of the baby is male?

MS. BROWN: Again, objection to form.

THE WITNESS: You have described a common experience of individuals receiving an ultrasound at 24 weeks, in which a sex is assigned and designated by a physician or an ultrasound tech.

BY MR. HILDABRAND:
Q. So in some cases, sex could be assigned while the mother is still pregnant before birth?
A. A designation could be made before birth.
Q. So before birth we've established that you could designate a sex before then. If the doctor does not -- some parents don't want to know the baby's sex until the baby is born. That is a common occurrence.

Would the baby still have a sex while in the womb even if the doctor has not designated what the

sex of the baby is?

MS. BROWN: Objection to form.

THE WITNESS: As I have shared previously, there are aspects of sex which may be present and the sex would be then assigned or designated at birth.

BY MR. HILDABRAND:

Q. But you cannot say that the baby in the womb has a sex?

MS. BROWN: Objection to form.

THE WITNESS: Again, we use the terminology of sex assigned at birth.

BY MR. HILDABRAND:

Q. I understand that you use that terminology. But are you telling me that the baby in the womb does not have a sex even though other babies in the womb could be assigned a sex?

MS. BROWN: Again, objection to form. And, Clark, I'm just going to note that, again, she's repeatedly said there are aspects of sex and I'm just confused --

MR. HILDABRAND: I understand that's what she has said, but she has not answered the question that was asked. I understand that she has answered the question she wanted asked, but she has

not answered the question that was asked.

THE WITNESS: Can you remind me of the question that was asked then, please?

BY MR. HILDABRAND:

Q. Yes. So we have established that some babies can have their sex assigned while they are in the womb. Other parents do not want to learn the baby's sex until the child is born. In those cases where the doctor has not said this child's sex is male or female, would the baby still have a sex in the womb before birth?

MS. BROWN: Same objection.

THE WITNESS: My previous answer stands, that a baby would have aspects of sex and that would be then designated a sex at birth for those parents that were not aware of what had been designated previously.

BY MR. HILDABRAND:

Q. Let's go ahead and move on, then. In paragraph two of your report, this is up on page one.

A. We are there.

Q. Do you see where you used the word "gender", consistent with their gender?

A. I see use of the word "gender" and consistent

with their gender, yes.
Q. So let's move forward to page three, paragraph 12. Do you see where it says: A person's gender identity refers to their inner sense of their own gender? Again, do you use the noun --
A. I'm sorry, can you give us one moment?
Q. Of course. Take as much time as you need.
A. You said read paragraph 12; is that right?
Q. That is correct.
A. Okay. Paragraph 12. I see it now.
Q. So is the first sentence there, A person's gender identity refers to their inner sense of their own gender; is that correct?
A. That is correct.
Q. And you used the noun gender here at the end of this sentence, correct?
MS. BROWN: Objection to form.
THE WITNESS: Gender is at the end of a sentence, yes.
BY MR. HILDABRAND:
Q. And this may take some time if you want to review the document. But can you review your report and let me know if anywhere in your report you define the noun gender?
MS. BROWN: Same objection. And we'll

take the time to review. Doctor, is there anywhere you would like me to start or at the beginning?

THE WITNESS: We can start right here.

MS. BROWN: Again, just let me know when to scroll.

THE WITNESS: Okay. Okay. We can scroll. We can scroll. We can scroll further. We can scroll down. We can scroll. We can scroll. We can scroll further. We can scroll down. We reviewed the document. Can you repeat the question?

BY MR. HILDABRAND:

Q. Of course. Thank you for reviewing it. In your report, do you define the noun gender anywhere?

MS. BROWN: Same objection.

THE WITNESS: So in my report I define gender identity.

BY MR. HILDABRAND:

Q. To go back to the question, did you define the noun gender?

A. Gender is based on an individual's gender identity.

Q. So in paragraph 12, the definition of a person's gender identity refers to the inner sense of their own gender. Is it your position that gender itself is defined by gender identity?

MS. BROWN: Objection to form.
THE WITNESS: So here we have a definition of a person's gender identity refers to their inner sense of their own gender in paragraph 12.
BY MR. HILDABRAND:
Q. Yes. Are gender and gender identity distinct concepts?
A. Not that I am aware of.
Q. So is it your understanding that gender identity and gender are the same concepts?
MS. BROWN: Objection to form.
THE WITNESS: So an individual's gender identity is their sense of -- of their own gender. I'm sorry, I don't think I understand what you're getting at.
BY MR. HILDABRAND:
Q. Of course. So my concern is, I'm trying to -- how did you define gender in your report? You referred to the definition of gender identity here, but what is the definition of the gender that you provide in your report, or did you not provide a definition of gender in your report?
MS. BROWN: Objection to form.
THE WITNESS: I provided a definition of

gender identity. And based on my experience and review of the literature would be happy to expand further and discuss the social construct that is gender.

BY MR. HILDABRAND:

Q. So gender is a social construct?

A. Gender is a social construct that is representative of many different aspects of an individual's experience in the world and what's most important to here is that we're talking about what is a person's sense of their own gender.

Q. Did you define -- did you provide that definition of gender in your expert report?

MS. BROWN: Objection to form.

THE WITNESS: We've established that here it is a definition of gender identity.

BY MR. HILDABRAND:

Q. Yes. I think we have established that you provided a definition of gender identity. Please point me to the page in your report where you define the word "gender", not the word "gender identity", the word "gender".

A. So although there may not be a definition of gender specific in the pages of this report, I'm happy to provide an opinion and information about

that definition based on some of the same things that were used to draft the report, which would include review of the literature and my professional experience.

Q. Before we do that, can you point me to the paragraph in your report where you define the word "gender" or did you not define the word "gender" in your report?

MS. BROWN: Objection to form.

THE WITNESS: My experience is that gender is best understood by a person's inner sense of their own gender and gender identity. And so I believe that it is captured in this report by reflecting an individual's inner sense of their gender.

BY MR. HILDABRAND:

Q. Which paragraph in this report defines gender?

A. Here we are looking at paragraph 12, which refers to gender identity and the importance of an individual's inner sense.

Q. So this is your definition of gender in your report?

MS. BROWN: Objection to form.

THE WITNESS: This is a definition of

gender identity and the construct and importance of an individual's inner sense. There may be other information that we can use to break down or to understand the noun gender specifically if that would be helpful.

BY MR. HILDABRAND:

Q. Do you break down the word "gender" in paragraph 12?

A. I do not.

Q. Thank you. And there is no other paragraph in this report that breaks down the word "gender", correct?

MS. BROWN: Objection to form.

THE WITNESS: In the report, there is no additional information about the definition of the term "gender".

BY MR. HILDABRAND:

Q. Thank you. I'm glad we got there.

MS. BROWN: We've been going about an hour, so we'd like a ten-minute break when it's convenient for you. If you have another question that you want to ask...

MR. HILDABRAND: That's a great place to pause for me. Glad to go off the record.

MS. BROWN: Okay. Thank you.

(Recess observed.)
BY MR. HILDABRAND:
Q. Turning back to your expert report, Exhibit 1, Doc A. We are going to go to paragraph 13, which straddles pages three and four.
A. Okay. Paragraph 13. We are there.
Q. Great. Do you see where you write that: Non-transgender people, also referred to as cisgender people, have a gender identity that aligns with their sex assigned at birth. Transgender people have a gender identity that is incongruent within the sex they were assigned at birth. Is that what you wrote here?
A. Yes. That's what's in my report.
Q. And do you still agree with that statement? And feel free to answer and explain further as you need.
A. I believe the report captures the definition of cisgender people and transgender people.
Q. So are there two categories, cisgender people on the one hand and transgender people on the other hand; is that correct?
MS. BROWN: Objection to form.
THE WITNESS: In the report, I'm offering definitions of cisgender and transgender.

However, in the current terminology, there are many categories of a gender identity.
BY MR. HILDABRAND:
Q. So are there additional categories besides transgender and cisgender?
MS. BROWN: Object to the form.
THE WITNESS: Our terminology is often evolving and changing, and there are other gender identities that people may have, yes.
BY MR. HILDABRAND:
Q. So going back up a little bit to paragraph 12, on page three, do you see the last sentence: Every person has a gender identity? Is that what you wrote?
A. That is in the report, yes.
Q. So do you still agree today that every person has a gender identity?
A. Yes, every person has a gender identity.
Q. Does every person have just one gender identity?
MS. BROWN: Objection to form.
THE WITNESS: So the terminology that an individual may use to describe their own gender identity may reflect multiple identities and yet we each have a sense of our own gender, as written in

the report, right, that define our gender identity.
BY MR. HILDABRAND:
Q. So just to make sure I'm understanding you, it could be that they have one sense but they could sense that they have multiple identities?
MS. BROWN: Objection to form.
THE WITNESS: So I'm sharing that a person has a gender identity that refers to their own sense of gender, and what terminology or understanding of their gender is is unique to each individual.
BY MR. HILDABRAND:
Q. So if it's unique to each individual, have you ever encountered someone who claims to have multiple gender identities?
MS. BROWN: Objection to form.
THE WITNESS: I have met individuals in my clinical practice who identify as gender fluid.
BY MR. HILDABRAND:
Q. Can you explain what gender fluid means?
A. Gender fluid is a gender identity in which an individual may have an inner sense of gender that is consistent with male, female, neither, or both, and that that may fluctuate over time.
/ /

BY MR. HILDABRAND:
Q. You said a minute ago that gender identity is unique. How many gender identities would you estimate there are?
MS. BROWN: Objection to form.
THE WITNESS: I do not currently have a way to quantify the number of gender identities. Again, the terminology is often changing and being updated and there may be many gender identities or individual gender identity may have an understanding or a terminology that has not yet been published or used by others.
BY MR. HILDABRAND:
Q. Fair enough. Just to get a sense of the numbers that we are talking about, are there more than two gender identities that you've encountered?
A. Yes, there are more than two gender identities.
Q. Are there more than three gender identities?
A. There are more than three gender identities. In fact, there's an infinite number of gender identities.
Q. Thank you. Going down to paragraph 16 in your report. This is on page four.
A. Did you say paragraph 16?

Q. Yes.
A. Is that correct? Okay. Yes, we're there.
Q. So do you cite the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision? Do you cite that in that paragraph?
A. Yes, that is referenced. Yes.
Q. Who publishes the DSM?
A. The American Psychiatric Association.
Q. Do you use that in your practice?
A. It is common and part of the best practice in mental health to rely on the DSM.
Q. And that's published by the American Psychiatric Association, right?
A. Yes, it is published by the American Psychiatric Association.
Q. And you not a psychiatrist, correct?
A. I am not a psychiatrist, although I am very familiar and well trained in the DSM, and it is part of our best practice as psychologists, as perhaps individuals with Master's degrees who have other backgrounds in mental health, to rely on and use the DSM.
Q. So it's common for nonpsychiatrists, like psychologists or other individuals you described, to

use the DSM as well?
A. Yes.
Q. How does -- does the DSM 5 use the term "gender dysphoria"?
A. It does.
Q. Are you aware of previous editions of the DSM using other terminology to refer to that?
MS. BROWN: Objection to form.
THE WITNESS: It says: Previous editions of the DSM, which are no longer considered valid and appropriate in the field, refer to other disorders by other names.
BY MR. HILDABRAND:
Q. Was the phrase "gender identity disorder" one of the terms previously used in earlier editions of the DSM?
A. It was previously used.
Q. But since the DSM Edition 5 published in 2013, is that phrase no longer commonly used?
A. That is correct.
Q. Is one of the treatments for gender dysphoria in the DSM surgery?
MS. BROWN: Objection to form.
THE WITNESS: We could reference the DSM specifically. How the DSM is used is often to

outline a list of symptoms and psychological or psychosocial diagnoses that are the label to describe a symptom cluster. There is additional information in the DSM about backgrounds of disorders and how the symptoms may have been derived as a cluster.

BY MR. HILDABRAND:

Q. Have any of your patients in your practice received surgery as treatment for gender dysphoria?

MS. BROWN: Again, objection to form.

THE WITNESS: In my practice, I have worked with adolescents and young adults who have received surgical interventions as one aspect of their treatment for gender dysphoria.

BY MR. HILDABRAND:

Q. So surgical intervention can be one aspect of treating gender dysphoria?

MS. BROWN: Objection to form.

THE WITNESS: The interventions and treatment plan for individuals with gender dysphoria is unique to each individual and surgery may be one component of their treatment plan.

BY MR. HILDABRAND:

Q. Are there any other mental health issues that you are aware of that are treated with surgery?

MS. BROWN: Objection to form.

THE WITNESS: Yes, I'm aware of other mental health conditions that may be treated with surgery.

BY MR. HILDABRAND:

Q. Would body dysmorphic disorder be treated with surgery or is surgery one option for treating body dysmorphic disorder?

MS. BROWN: Objection to form.

THE WITNESS: Body dysmorphic disorder an individual may wish to seek surgery as part of the diagnosis and experience of body dysmorphic disorder.

BY MR. HILDABRAND:

Q. Is it appropriate for health providers to provide the surgical interventions that that body dysmorphic individual seeks?

MS. BROWN: Objection to form.

THE WITNESS: A mental health provider would not be offering surgical intervention in performing those surgical interventions, no.

BY MR. HILDABRAND:

Q. Would they recommend surgical interventions for or is there a scenario where a mental health provider would recommend surgical interventions for

an individual with body dysmorphic disorder?
A. In my practice, I have not treated an individual with body dysmorphic disorder so I cannot say.
BY MR. HILDABRAND:
Q. Fair enough. Going forward a little bit to page five, footnote seven.
MS. BROWN: I'm sorry, did you say page or paragraph five?
BY MR. HILDABRAND:
Q. Page five, footnote seven.
A. Page five, footnote seven. Yes, we are there.
Q. So not as a substantive question, but do you cite an article here where the first author is Hembree, Endocrine Treatment of Gender Dysmorphic/Gender Incongruent Persons, an Endocrine Society Clinical Practice Guideline?
A. Yes.
MR. HILDABRAND: Travis, can you circulate, I believe it's Document B. And we will mark this as Exhibit 2.
(WHEREUPON, a document was marked as Exhibit Number 2.)
/ /

BY MR. HILDABRAND:
Q. Can you identify what this document is?
A. This document is the article by Hembree, et al., titled, Endocrine Treatments of Gender Dysphoric, Gender-Incongruent Persons, and Endocrine Society Clinical Practice Guidelines.
Q. And would you refer to this as the Endocrine Society Guideline?
A. Yes.
Q. So let's go -- oh, before we scroll down, on the list of authors, just because of this case, do you see the name Joshua D. Safer?
A. I see that name, yes.
Q. So he would be one of authors on this document?
A. It appears that way, yes.
Q. Thank you. All right. Scrolling down to it's page 3873 in the Journal. It's page five in the PDF.
A. We are on page five of the PDF. Yes.
Q. All right. Thank you. So down in the bottom right-hand column, do you see the line that begins yet such a classification?
A. Can you scroll down a little bit? Yet such a classification, yes.

Q. I'm going to just read it out so we have a copy of it. Does it say: Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience having both a male and female gender identity, whereas others completely renounce any gender classification. Did I read that correctly?

A. Yes.

Q. Would you agree that some individuals experience themselves as having both a male and female gender identity?

MS. BROWN: Objection to form.

THE WITNESS: I do agree that some individuals have gender identity consistent with a male and female gender identity.

BY MR. HILDABRAND:

Q. And the second part of that is: Whereas others completely renounce any gender classification.

Are there some individuals that you're aware of who renounce any gender classification?

MS. BROWN: Objection to form.

THE WITNESS: In the field is established that others renounce gender

classification and labels.
BY MR. HILDABRAND:
Q. Thank you. So going on to the line, there are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity or men who do not experience themselves as men but do not want to live as women. So looking at the first part of that sentence, do you agree that some individuals experience a continuous and rapid involuntary alternation between a male and female gender identity?
A. There are some individuals who experience alternations between male and female identity.
Q. And the second half of that sentence, are there some men who do not experience themselves as men but do not want to live as women; would you agree with that?
A. I agree there are some individuals who may reject the sex they were assigned at birth and do not identify in a binary identity.
Q. So if they were born male at birth, they'd reject -- make sure I'm understanding. They reject being male but they don't necessarily want to be female either; is that your understanding?

MS. BROWN: Objection to form.

THE WITNESS: There are individuals whose sense of gender may not fall on the gender binary, so who may not identify with the sex they were assigned at birth or another binary gender identity.

BY MR. HILDABRAND:

Q. So they wouldn't want to be a binary male or female; they might want to be something else?

MS. BROWN: Objection to form.

THE WITNESS: It's not just a question of what they want to be so much as who they are in their gender identity.

BY MR. HILDABRAND:

Q. So would they view who they are as something else besides a binary male or a binary female?

A. Some individuals do not identify as a binary male or a binary female.

Q. Is that what the phrase "nonbinary" refers to, or is that one understanding of what nonbinary means?

MS. BROWN: Objection to form.

THE WITNESS: Individuals who identify as nonbinary tend to have a gender identity that exists outside the gender binary of male or female.

BY MR. HILDABRAND:
Q. Thank you for -- thanks for explaining.
All right. Let's go to page 11 in the PDF. That's page 3879 in the way the Journal does its paging.
A. Page 11 of the PDF. We are there.
Q. Before we ask about this, the Endocrine Society Guideline is something that you rely upon in your practice, correct?
A. Yes. We rely on the Endocrine Society Guidelines.
Q. All right. On the bottom left-hand column, do you see the sentence that begins, However, social transition?
A. On the bottom of the first paragraph, yes.
Q. So does it say: However, social transition in addition to GD/gender incongruence has been found to contribute to the likelihood of persistence? Did I read that accurately?
MS. BROWN: Objection.
THE WITNESS: That statement is in the document and would be important to be considered in context and with the evolving state of the literature.
/ /

BY MR. HILDABRAND:

Q. Feel free to explain further, but do you agree with that statement?

MS. BROWN: Again, objection to form. You read one line of this. Just noting that objection.

BY MR. HILDABRAND:

Q. Would you agree that social transition is likely to contribute to persistence?

MS. BROWN: Objection to form.

THE WITNESS: I am not aware of the data and scientific findings that support this particular claim that social transition contributes to the likelihood of persistence.

BY MR. HILDABRAND:

Q. In your practice, has it been your experience that social transition is likely to contribute to persistence in an expressed gender identity?

MS. BROWN: Again, same objection.

THE WITNESS: In my professional experience, individuals who make a social transition often persist in their gender identities, including because of the significant distress and identification with transgender identity that precipitated the social transition.

BY MR. HILDABRAND:
Q. Is social transition likely to encourage persistence or does it discourage persistence?
MS. BROWN: Objection to form.
THE WITNESS: I am not aware of the evidence that suggests the social transition specifically contributes to persistence.
BY MR. HILDABRAND:
Q. So you wouldn't know if it is likely to or is not likely to contribute to persistence?
MS. BROWN: Same objection.
THE WITNESS: Whether it is likely to or not likely to is a research question that I'm not aware of.
BY MR. HILDABRAND:
Q. And so that's something that you would need further research on?
MS. BROWN: Objection to form.
THE WITNESS: It is important for us to continue to study and to understand phenomenology in all aspects of psychological mental health and medical science, and understanding particulars of persistence may be one area that would benefit from further study.
/ /

BY MR. HILDABRAND:
Q. Is it established in the field of psychology whether social transition contributes to the likelihood of persistence?
MS. BROWN: Objection to form. Again, you've asked this question. It's been asked and answered some, Clark.
MR. HILDABRAND: This is a different question from what I asked and I had asked it definitely precisely because you've objected to the form several times, so I'd like her to answer the question.
MS. BROWN: I'm just letting you know I'm not hearing a different question, so I'm going to continue to object.
MR. HILDABRAND: That fine. I'll keep asking a different question.
BY MR. HILDABRAND:
Q. So is it established in the field of psychology whether social transition contributes to the likelihood of persistence?
MS. BROWN: Same objection.
THE WITNESS: To my knowledge and review of the literature, it has not been established that a social transition contributes to persistence.

BY MR. HILDABRAND:
Q. Thank you. So earlier we discussed the number of gender identities. What is your opinion on how many sexes there are?
MS. BROWN: Objection to form.
THE WITNESS: So to state your question, that would be best directed at one of my interdisciplinary colleagues. You could speak to the medical aspects and definitions of sex, that there may be multiple -- I'm trying to remember the word that you used -- multiple sexes, for lack of a better term.
BY MR. HILDABRAND:
Q. But that's not something -- to be fair, that's not something you would be best situated to answer?
MS. BROWN: Objection to form.
THE WITNESS: I am able to speak to an individual's sex assigned at birth and how that relates to their gender identity.
BY MR. HILDABRAND:
Q. But not to the question of how many sexes there are?
MS. BROWN: Objection to form.
THE WITNESS: I previously stated that

there may be multiple sexes and that a medical provider may be able provide more information.
BY MR. HILDABRAND:
Q. Different question. How many genders are there?
MS. BROWN: Objection to form.
THE WITNESS: We've established that are many different gender identities.
BY MR. HILDABRAND:
Q. How many different? Are there more than two?
A. I believe we previously established there were more than three and an infinite number of possibilities.
Q. To clarify, we previously discussed the number of gender identities. How many genders, not gender identities, are there? How many genders are there?
A. So an individual gender identity is their understanding of their inner sense of gender, and I don't believe that those two can be separated.
Q. So there could also infinite genders?
MS. BROWN: Objection to form.
THE WITNESS: There are many different gender identities which reflect an individual's inner sense of gender, yes.

BY MR. HILDABRAND:
Q. Yes. So given as you testified earlier that there can be infinite gender identities, can there also be infinite genders? Please answer yes or no and then feel free to elaborate.
A. Yes, I believe there are many different gender reflected as a person's gender identity and their own sense of gender.
Q. So to return to the question, yes or no. Can there be infinite genders?
A. I believe I just answered that question and my previous answer stands.
Q. Can you provide a yes or no answer to the question, are there infinite genders?
A. My previous answer included the word yes. I'm sorry if that was not legible and then an ongoing explanation that an individuals' gender identity, there may be many different gender identities reflected of the individual's inner sense of gender.
Q. Sorry, I'm not trying to just ask a question --
A. I'm sorry.
Q. -- so I'm sorry if I misunderstood you. So I just want to understand that your answer was yes,

there can be infinite genders and then you provided a fuller explanation that explained your answer; is that fair?

MS. BROWN: Objection to form. Again, I understand, Clark, that you want a yes or no answer and you can ask her that, but you can't command her answer. She's going to give her answer and that's her answer.

MR. HILDABRAND: I totally get that, too, but I did request a yes or no answer and I want to know what the yes or no answer was. And if she says she has said a yes or no, I also don't want to ask the same question again but I really would like a yes or no answer to this. So yes or no --

MS. BROWN: But there, again, it may just be a situation where, again, she's testifying as an expert. She's giving her opinions and answering your questions. And if she has to provide context and say yes, like she did, then that's going to be the answer.

BY MR. HILDABRAND:

Q. That's totally fine. At the same time, I need to know what the yes or the no is, not go straight into the explanation. I am happy to have her provide further explanation. But I would just

like to know the yes or no to the question, are there infinite genders? And provide any fuller explanation after that, but please begin with a yes or no or I don't know and then provide your fuller explanation to the question are there infinite genders.

MS. BROWN: You can answer the question again, but I'm going to, again, same objection to form that I have been noting.

THE WITNESS: So my previous answer stands. Yes, there are many different gender identities that are reflective of an individual's inner sense of gender.

BY MR. HILDABRAND:

Q. All right. Thank you. We'll move on from that. On page ten of the PDF, page 3878 in the Journal's paging.

MS. BROWN: Sorry, what was the page number?

BY MR. HILDABRAND:

Q. Of course. It's page 3878 or page ten in the PDF.

A. Page ten of the PDF. We are there.

Q. And feel free -- this starts on the previous page at 1.2 so feel free to read that if you want to

just to completely understand that. But can you just read to yourself 1.2 and then I'll ask you a question about part of that. But I want to make sure you've been able to see the entirety of it before the question. So can you please read 1.2?

A. Uh-huh. Scroll down. Okay. I have read 1.2.

Q. Great. And so do you see where it says that one of the factors that's important is the ability to make a distinction between GD/gender incongruence and conditions that have similar features, e.g., body dysmorphic disorder. Can you describe for us --

A. Yes.

Q. Thank you. I think we discussed this a little bit earlier, but can you define for us what body dysmorphic disorder is in your understanding?

A. My understanding of body dysmorphic disorder is a diagnostic label and psychiatric condition which an individual has a significant misrepresentation of their body and this creates distress for them.

Q. Is it your understanding that an appropriate treatment for that misunderstanding, would an appropriate treatment for that be surgery?

MS. BROWN: Objection to form.

THE WITNESS: So the specifics of body dysmorphic disorder may be better left to an expert in body dysmorphic disorder. I would suspect that an individualized treatment plan for an individual with body dysmorphic disorder would be crafted between that individual and their provider and may include an individual to pursue surgery.

BY MR. HILDABRAND:

Q. Are you aware of whether physicians at Vanderbilt provide surgery for body dysmorphic disorder?

A. I am not aware.

Q. On the right column here, do you see where it says: Examples of conditions with similar features are body dysmorphic disorder, bodily integrity -- sorry -- body identity integrity disorder, a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow how wrong or inappropriate?

A. I see that.

Q. Did you see that? Okay. And then does it mention eunuchism after that?

MS. BROWN: Sorry, Clark, you're coming through very choppy. I think there's an internet

connection issue. We are hearing bits and pieces of what you're saying.

BY MR. HILDABRAND:

Q. All right. I can hear y'all clearly. Do you see on the right column --

A. You're speaking but we're not able to hear you. I don't know if others are having the same problem.

MR. SANDERS: I'm not having any problem. I can hear everyone clearly.

MR. ROYER: Here as well.

MR. HILDABRAND: Can you hear everyone else?

MS. BROWN: Sorry, can folks hear us?

MR. HILDABRAND: We can hear y'all.

MS. RILEY-SWANBECK: Yes.

MR. HILDABRAND: I think the problem may be on y'all's end. Can y'all hear us?

MS. BROWN: I can hear you now. You're coming through clear again.

MR. HILDABRAND: Okay. Whatever was going on I'm glad it resolved. So that's how Zoom works.

BY MR. HILDABRAND:

Q. On the right-hand column here, do you see

where it provides examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder? Do you see that there?
A. Yes.
Q. And then it goes on to describe eunuchism, in which a person is preoccupied with or engages in castration and/or penectomy for reasons that are not gender identity related.
A. I see that.
Q. Is eunuchism a gender identity?
MS. BROWN: Objection to form.
THE WITNESS: Eunuchism is not a gender identity that I have encountered.
BY MR. HILDABRAND:
Q. Are you aware of literature in the psychological field describing eunuchism as a gender identity?
A. I am not.
Q. And I assume that's -- if you're not aware, I assume you're not aware of Vanderbilt treating anyone with castration for eunuchism?
A. I am not aware.
Q. All right. So earlier today we've talked about how you've given presentations to the Tennessee Department of Children's Services using

your psychological expertise, right?
A. Yes.
Q. Let's turn to page 18 of Exhibit 1, your expert report. This is PDF page 18. Page 18. CV page eight. Do you see where you list a February 27 --
A. We're not there quite yet. Slight malfunction, so very sorry.
Q. No problem. Take your time.
A. Page 18 of the PDF. We are there.
Q. All right.
A. We are there.
Q. All right. Do you see where you list a February 2017 presentation to DCS?
A. I do. Item five.
Q. And would that presentation reflect your psychological experience?
MS. BROWN: Objection to form.
THE WITNESS: So yes. This presentation was developed and delivered as a part of my professional expertise.
BY MR. HILDABRAND:
Q. Just one second.
A. Uh-huh.
MR. HILDABRAND: All right. Travis, can

you circulate Doc C, which I think we'll mark as Exhibit 3.

MR. ROYER: One moment. I think I -- Clark, you're familiar with our wonderful dual authentication system. I believe that I got kicked off. Give me one second.

MR. HILDABRAND: No problem. So what would I do to share, Travis? Do I copy and paste or what is the --

MR. ROYER: You could drag and drop or just hit the little paper symbol, do you see that, and skip to location there, or just drag and drop by the folder.

MR. HILDABRAND: Thank you-all for your patience with us.

MR. ROYER: Yes, thank you very much.

MS. BROWN: Of course. Of course.

MR. HILDABRAND: All right. I should have just circulated Doc C, which we'll mark exhibit -- well, sorry. What's -- we are going to mark this as a cumulative exhibit with the next couple. So if we can just hold off on marking it for right now. But this is Doc C if y'all want to pull this up.

MS. BROWN: Sorry, where did you

circulate it?

MR. HILDABRAND: Can y'all not see the document?

MS. BROWN: No. There's nothing in the chat.

MR. HILDABRAND: All right. Can we go off the record for minute while we sort this out?

(Off-the-record discussion.)

BY MR. HILDABRAND:

Q. Thank you. Now that we're back, can you please pull up Doc C?

A. We have it open.

Q. Thank you. Is that a picture of you on the upper right?

A. Yes, that is.

Q. And is this you giving the presentation back in February 2017?

A. It is.

Q. All right. On the left side from the presentation, can you read the quotation there and can you read it out loud?

A. Sure. So it says: Sexuality is much more than sex. It's our values, attitudes, feelings, interactions, and behavior. Sexual development is one part of sexuality and it begins much earlier in

life than puberty. Infants and children may not think about sexuality in the same way as adults but they learn and interpret messages related to sexuality that will shape their future actions and attitudes.

Q. All right. And did you include a picture on the left-hand side of the slide here?

A. There is a picture on the slide, yes.

Q. Can you please describe just for the transcript what the picture depicts?

A. It is a picture of two children who are engaged in play with what appears to be a stethoscope.

Q. What age would you say those children are, or what would be your best guess at what age those children are?

MS. BROWN: Objection to form.

THE WITNESS: The children in the image appear to be toddlers. I would estimate three to four years of age.

BY MR. HILDABRAND:

Q. And is one of them -- does one on the left appear to be a boy? Sorry. I don't know if that got through. Does the child on the left appear to be a boy?

MS. BROWN: Objection to form.

THE WITNESS: So I cannot make assumptions of their gender identity. The child on the left has stereotypically short hair and is wearing a striped shirt. They are also wearing pink glasses.

BY MR. HILDABRAND:

Q. And the child on the right, how would you describe their features or how would society describe -- are they stereotypically a girl?

MS. BROWN: Again, objection to form.

THE WITNESS: I could not assume this child's gender identity. They appear to be wearing a pink shirt, to have longer hair that is styled in pigtails.

BY MR. HILDABRAND:

Q. And the child on the right, is that child holding up the child's shirt?

A. The child on the right is holding up their own shirt, yes.

Q. And the child on the left, is that child touching the child on the right anywhere?

A. In my interpretation of the image, it appears as though the child on the left is holding a stethoscope and perhaps touching the stethoscope but

does not appear to be touching the child on the right.

Q. Thank you for providing that description. Around where on the child in the right's body is the child on the left placing the stethoscope?

A. The child on the left is placing the stethoscope on approximately the child on the right's chest.

Q. Thank you. Why did you select this picture for this slide?

A. This was many years ago, back in 2017, so I'll do my best to estimate why I selected that at the time. It is likely because this image represented typical play in childhood and which many toddlers and young children will play doctor or house in their imaginary play.

MR. HILDABRAND: All right. Travis, can you circulate Doc D.

MS. BROWN: Clark, before you do that, for the record, I'd like to clarify. Is the quote that you had Dr. Cyperski read attributable to the source at the bottom of the slide, which says National Sexual (inaudible) Center 2013?

(Court Reporter interrupts for clarification.)

MS. BROWN: Yes, I'll say it again. Clark, again, to clarify for the record, the quote that you had Dr. Cyperski read, is that attributable to the source at the bottom of the quote on the slide and in parentheses it says: National Sexual Violence Resource Center 2013?

BY MR. HILDABRAND:

Q. So just to clarify the record, you're citing -- you're quoting this source on the slide, correct?

MS. BROWN: I am asking if it's attributable to that source? Is that where you pulled the quote from that you had Dr. Cyperski read? Did you hear my question? Are we having audio issues again? Can folks hear me?

MR. HILDABRAND: I can hear you. I can't hear Dr. Cyperski.

MS. BROWN: Dr. Cyperski didn't say anything. I'm asking you about the quote that you've put on the slide and the source of the slide.

BY MR. HILDABRAND:

Q. So depositions are asking the witness questions, not asking other attorneys, so let's ask the witness. Did she pull this quotation from the National Sexual Violence Resource Center? It says

on the slide -- is that where you pulled the quotation from?
A. That would be my assumption on how the slide is developed. But the quotation that was read previously is attributed to the source from the national Sexual Violence Resource center in 2013.
MR. HILDABRAND: Thank you. Does that clear things up?
MS. BROWN: It does. And for the record, I'll just state that, again, this was a slide and exhibit that you prepared and a source that you included. And of course you're right, the witness is here to answer questions, but I just want to note that I asked you that question.
MR. HILDABRAND: And you of course have an opportunity to ask questions later on as well but I'm glad we can have it as accurate for the record as possible. All right.
BY MR. HILDABRAND:
Q. Let's turn to Doc D which was circulated. So does this also depict you on the right?
MS. BROWN: Sorry. Give us one moment.
BY MR. HILDABRAND:
Q. Okay.
A. This is an image of me on the right.

Q. And is it, again, the slide presentation on the left?
A. That is correct.
Q. So the left column, does it have a column that says stage of development?
A. Yes.
Q. And then underneath that, does it say early childhood, age two to five?
A. It does.
Q. And then there's a column in the middle that says common behavior; is that correct?
A. Yes.
Q. And then a column on the right that says caregiver tasks; is that correct?
A. Yes.
Q. Is one of the caregiver tasks for two- to five-year-olds to provide basic information about reproduction?
A. And it's listed as the first bullet point.
Q. And is consensual and playful exploration with peers, e.g., playing doctor, is that in the common behavior column?
A. It is.
Q. So do you agree today that consensual and playful exploration with peers, e.g., playing

doctor, is a common behavior for two- to five-year-olds?

MS. BROWN: Objection to form.

THE WITNESS: Children in early childhood often engage in consensual and playful exploration with peers in a variety of ways.

BY MR. HILDABRAND:

Q. So to provide a yes or no answer, is it common behavior, yes or no, for two- to five-year-olds to engage in consensual and playful exploration with peers, e.g., playing doctor, yes or no?

MS. BROWN: Same objection.

THE WITNESS: Yes.

BY MR. HILDABRAND:

Q. On the right --

MS. BROWN: Are you finished? So before your next question, I'm going to -- as long as you continue this line of questioning, I'm going to raise a standing objection to scope as we're talking about sexuality here. And, again, for the record, I believe you're conflating sexuality with gender identity and that's going to be my standing objection and I'll continue to make objections. You may proceed.

MR. HILDABRAND: Yes. I believe we agreed to do form objections in this case and not -- I understand you're trying to explain your position but you've talked a lot in the past half hour. That's not how we've been conducting these depositions. And that may be your perspective on the scope of it, but she is testifying as a psychologist and has talked about sexual issues throughout her report.

So I think that's why we are asking these questions today and that's something we can work out later. But for now, please, if you want to object to form whenever you would like.

BY MR. HILDABRAND:

Q. On the right --

MS. BROWN: Yes.

MR. HILDABRAND: So on the right -- all right. Let's turn to -- Travis, can you circulate Doc E.

THE WITNESS: I think we're getting a new document.

MS. BROWN: We have the document open. But, again, for the record, a standing objection to the extent Mr. Hildabrand is questioning the witness about collective slides from what appear to be

larger presentations. You may proceed. We have D open.

MR. HILDABRAND: And we're glad to circulate the -- and, actually, I'll circulate the YouTube link right now if that's what you'd like. And in a minute we will enter the entire video as an exhibit.

MS. BROWN: This is your time. If you'd like to do that, that's fine. I just noted my objection.

MR. HILDABRAND: That's great.

BY MR. HILDABRAND:

Q. All right. On this document -- so do you see I circulated a link to a YouTube page? All right.

A. Yes. We see that in the chat.

Q. Thank you.

A. But we have not opened the link to confirm.

Q. Okay. Can you pull up Doc E? Are you looking at that now? All right. On Doc E, is that, again, you on the right?

A. Yes, this is me in Doc E.

Q. And is there a slide show presentation on the left?

A. There is.

Q. Are there, again, columns labeled stage of

development, common behavior, and caregiver tasks?
A. Yes. They are columns which reflect tables from the source about sexual development.
Q. Is it your understanding that sexual development, is that relevant to the report that you are providing in this case?
A. The report that I provided was within the scope of gender identity and gender dysphoria in individuals who identify as transgender in their treatment, including the treatment guidelines. Sexual development is an important part of childhood development but it's distinct from an individual's gender identity.
Q. So sexual development is not relevant to your report on gender identity; is that correct?
MS. BROWN: Objection to form.
THE WITNESS: Sexual development and gender identity, even say sex identity or sexuality are distinct concepts.
BY MR. HILDABRAND:
Q. So yes or no, sexual development is not relevant to your expert report?
MS. BROWN: Same objection.
THE WITNESS: Again, I would like to make clear that sexual development and identity are

different than gender identity. So I'm not sure how to answer your question with that.

BY MR. HILDABRAND:

Q. So you can't give -- you can't say that this is not sexual -- you cannot say that sexual development is not relevant to your report?

MS. BROWN: Same objection.

THE WITNESS: Sexual development is an important part of childhood development and to the scope that, you know, I can provide expert information about child and adolescent development.

BY MR. HILDABRAND:

Q. But you cannot provide a yes or no answer to that question?

MS. BROWN: Same objection.

THE WITNESS: I'm sorry, I don't mean to be obstinate. I just -- I'm not sure how to answer the question because they're different concepts.

BY MR. HILDABRAND:

Q. Okay. That's fair. Let's ask a few questions about this and then we'll go out to lunch at that point.

A. Okay.

Q. So here is the stage of development listed middle childhood, age five to eight?

A. Yes.
Q. And in the common behavior column, does it say may start showing interest in opposite sex?
A. Yes.
Q. And you used the phrase "opposite sex" here, correct?
A. Yes.
Q. Then the slide says, common behavior includes masturbation for pleasure, increasingly in private. Is that what you said here?
A. Citing the source that's listed at the bottom of the slide; however, that information is listed on the slide.
Q. Would you agree that masturbation for pleasure, increasingly in private, is common behavior for five- to eight-year-olds?
MS. BROWN: Objection to form.
THE WITNESS: Masturbating for pleasure, increasingly in private, is listed as a common behavior and supported in the literature as a common behavior in childhood.
BY MR. HILDABRAND:
Q. Thank you. On the right lists caregiver tasks. Do you see where it says: Promote understanding of gender and how children experience

their identity? Is that what you said on the first bullet?
A. Again, this is citing a particular source. Then we would -- we could verify within that source that is what's listed on the slide to promote understanding of gender and how children experience their identity.
Q. So in your opinion, is that an appropriate caregiver task to help five-to eight-year-olds understand gender and how they experience their gender?
A. I think this is a caregiver task across development in childhood and adolescence, that children, adolescents, and young adults can be supported in understanding concepts about themselves in the world around them, including gender.
Q. Including at ages five through eight, correct?
MS. BROWN: Objection.
THE WITNESS: Yes. Ages five through eight in and across development.
BY MR. HILDABRAND:
Q. Does it also say on the right that a caregiver task is to explain basics of reproduction, including vaginal intercourse? Is that what the

slide says in the second bullet?

MS. BROWN: Sorry, I did not mean to interrupt you. Again, I'm going to note my objection. Clark, I understand but I'm going to say it again. I'm objecting to scope for all of these questions and I'm going to continue.

MR. HILDABRAND: Yes. Just object to form, as was agreed by both parties before the deposition. So I'll repeat my question.

BY MR. HILDABRAND:

Q. On the right-hand side, does it say: Explain basics of reproduction, including vaginal intercourse? Is that in the caregiver task column?

MS. BROWN: Same objection.

THE WITNESS: That is listed in the caregiver task column in this image.

BY MR. HILDABRAND:

Q. Do you agree today that this is an appropriate caregiver task for children ages five through eight?

MS. BROWN: Same objection.

THE WITNESS: Yes. It is an important task for caregivers to provide information and explain basics of reproduction to children.

/ /

BY MR. HILDABRAND:
Q. Farther down that column, do you say: As a caregiver task, explain differences in sexual orientations? Is that an appropriate caregiver task for children ages five through eight?
MS. BROWN: Same objection.
THE WITNESS: Yes.
BY MR. HILDABRAND:
Q. And then, finally, is there also listed in the caregiver task column for children ages five through eight, teach that masturbation is something that occurs in private; is that listed?
MS. BROWN: Same objection.
THE WITNESS: It is listed.
BY MR. HILDABRAND:
Q. Is that an appropriate caregiver task for children ages five through eight?
MS. BROWN: Same objection.
THE WITNESS: It is appropriate within the family's value system and is an important part of an individual's development.
BY MR. HILDABRAND:
Q. Is the family's value system referenced on this slide?
A. On this particular slide, it is not

referenced; however, it was several slides previously and within the context of this presentation, if I recall correctly.

MR. HILDABRAND: Thank you. That's the logical end point for questions right now if y'all want to break for lunch.

MS. BROWN: Before that, quickly, if you'll give me one moment before we go off the record.

MR. HILDABRAND: Before we go off the record, I'll enter collectively as Exhibit 3. This presentation will be Exhibit 3.

(WHEREUPON, documents were marked as Collective Exhibit Number 3.)

MS. BROWN: When you say presentation, are you speaking about the YouTube link you inserted?

MR. HILDABRAND: Yes. This entire presentation will be Exhibit 3. And these clips are from that presentation, so this is collectively Exhibit 3. If you'd like me to, I can enter the clips as a separate exhibit if that's what you'd prefer but that's how we -- is that fine with you?

MS. BROWN: I'm requesting that all the presentations be separately entered in as exhibits.

MR. HILDABRAND: All right. So we'll enter the screenshots collectively as Exhibit 3. The presentation will be Exhibit 4. If that's the case, let's go and pull up this presentation. If you can click the YouTube link in there just so we can establish that this is the presentation.

(WHEREUPON, a document was designated to be marked as Late-filed Exhibit Number 4, when provided.)

MS. BROWN: Okay. We have the presentation playing.

MR. HILDABRAND: Great. So on the first page, do you see -- I'm sorry. Let's play a little bit. At point -- at the first second of the video, if you can go there?

MS. BROWN: Sorry, the second?

MR. HILDABRAND: Yes. 0:01 of the presentation. Just go there.

MS. BROWN: Okay.

BY MR. HILDABRAND:

Q. Do you see -- Dr. Cyperski, do you see yourself in the upper right corner of this video?

A. Yes.

Q. And is there a slide show presentation on the left that says: Sexual behavior problems toward

health and healing for children, adolescents, and their families; is that correct?
A. Yes.
Q. All right. Now let's go to 239. Just go there. We don't need to watch it.
Is that the same slide that we discussed as Doc C?
A. It appears so, yes. If I could, like to request to take a break soon.
Q. Yes. I'm just going to go and just confirm for the other two and then take a break at that point.
A. Okay.
Q. I know we wanted to end at noon but I just wanted to -- so we don't have to go back and confirm each of these.
Let's go now to 3:52 in the video. I'm sorry. This one is -- sorry 5:52 in the video. At 5:52 in the video, do you see a slide that lists stage of development, common behavior, and caregiver tasks?
A. So early childhood age two through five, yes.
Q. Yes. And is that the same slide that we discussed earlier as Doc D?
A. Yes.

Q. All right. Last time, let's go to I think it's seven minutes into the video. Is that the same slide that we discussed as Doc E?
A. It appears that way.
MR. HILDABRAND: That's all that I have if y'all want to take a break now.
MS. BROWN: Okay. I need to say -- we can go off the record.
(Recess observed.)
MR. HILDABRAND: Let's go back on the record. All right. Now that we are back on the record, I have that we've spent two hours and 20 minutes so far in the deposition. Now that we are back, I just want to note, we discussed this off the record a little bit, but my understanding is under the Federal Rules of Civil Procedure 30(c)(2) is that an objection must be stated concisely in a non-argumentative and non-suggestive manner. If there is a concern about speaking objections and coaching, I will put that on the record, that's fine, and we reserve the right to request from the court any further action that we deem necessary to make sure that our deposition is carried out. All right. To restart.
BY MR. HILDABRAND:

Q. Is the mental health of children relevant to your report?

MR. ROYER: Clark, hold on one second. Their mic is still activating.

MR. HILDABRAND: Oh.

MS. BROWN: Okay. We're back.

BY MR. HILDABRAND:

Q. Great. Is the mental health of children relevant to your report?

A. Yes.

Q. Is the psychological development of children relevant to your report?

A. Yes.

Q. Is a child's experience of identity relevant to your report?

A. Yes.

Q. Are the changes that occur during puberty relevant to your report?

MS. BROWN: Objection.

THE WITNESS: The changes that occur during puberty may be considered in part of a gender-affirming process.

BY MR. HILDABRAND:

Q. All right. Is instruction of children about sex relevant to your report?

MS. BROWN: Objection to form.
THE WITNESS: Can you say what you mean?
BY MR. HILDABRAND:
Q. Is instructing children about sexual acts relevant to your report?
MS. BROWN: Objection to form again.
THE WITNESS: What does instructing children about sexual acts mean?
BY MR. HILDABRAND:
Q. Is teaching children about sexual acts relevant to your report?
MS. BROWN: Same objection.
THE WITNESS: Not that I'm aware. Although talking about sexual identity and an individual's sense of identity may be.
BY MR. HILDABRAND:
Q. Is sex as a noun to refer to someone's sex, is that relevant to your report?
MS. BROWN: Objection to form.
THE WITNESS: Again, what do you mean by sex in this context?
BY MR. HILDABRAND:
Q. Not necessarily how I understand it but is sex assigned at birth relevant to your report?
A. Yes.

Q. Is the privacy of children a relevant consideration for your report?

MS. BROWN: Objection to form.

THE WITNESS: What do you mean by privacy?

BY MR. HILDABRAND:

Q. Is the privacy of children in exposing or not exposing their genitalia a relevant consideration in your report?

MS. BROWN: Objection to form.

THE WITNESS: Discussing whether a child is exposing their genitalia to others is not relevant.

BY MR. HILDABRAND:

Q. Can we turn to paragraph 26 in your report. That's Doc A, Exhibit 1, at the bottom of page seven, going on to the top of page eight.

MS. BROWN: I'm sorry, can you provide me with the page number again?

MR. HILDABRAND: Of course. Bottom of page seven, top of page eight. The paragraph goes on to both.

THE WITNESS: Okay. We're on the bottom of page seven.

/ /

BY MR. HILDABRAND:
Q. You say there that maintaining privacy about one's transgender identity can be important to safety given the persistence of harassment and even violence exhibited against transgender people.
A. Yes.
Q. So is maintaining privacy relevant to your report?
MS. BROWN: Objection to form.
THE WITNESS: It may be helpful to know in what specific context we're talking about maintaining privacy as the reports states maintaining privacy about one's identity can be important to their safety.
BY MR. HILDABRAND:
Q. How do you understand the term "privacy" that you used here? What's your understanding of that?
MS. BROWN: Objection to form.
THE WITNESS: My interpretation is privacy representing confidentiality.
BY MR. HILDABRAND:
Q. What sort of confidentiality are you talking about?
MS. BROWN: Objection to form.
THE WITNESS: Is the question about in

the report?
BY MR. HILDABRAND:
Q. You just used the word "confidentiality". In your answer that you gave, what do you mean by confidentiality?
A. I was providing an answer about the definition of privacy. So in this sentence in the report might be that maintaining confidentiality about one's identity could be important to safety.
Q. So not having other people know that one is transgender could be relevant to privacy?
MS. BROWN: Objection to form.
THE WITNESS: Maintaining confidentiality about their identity can be important to safety and that would include about their gender identity.
BY MR. HILDABRAND:
Q. Thank you. Is the understanding of gender identity among psychologists still developing?
MS. BROWN: Objection to form.
THE WITNESS: I'm not sure what you mean still developing.
BY MR. HILDABRAND:
Q. Are there still aspects of gender identity that psychologists disagree about?

MS. BROWN: Objection to form.
THE WITNESS: It's common in medical and scientific fields for the literature or terminology to continue to be evolving with new study and evidence and in that way it is possible that things are still evolving.
BY MR. HILDABRAND:
Q. Is this a rapidly evolving field?
MS. BROWN: Objection to form.
THE WITNESS: What do you mean by rapidly?
BY MR. HILDABRAND:
Q. We can come back to that in a minute. Is there much data on the mental health in transgender children?
MS. BROWN: Objection to form.
THE WITNESS: There is a significant body of evidence about mental health in transgender children.
BY MR. HILDABRAND:
Q. Are most of the studies on transgender mental health based on small sample sizes?
MS. BROWN: Objection to form.
THE WITNESS: I would need to see specific numbers of sample sizes that you referenced

and this would be specific to each article.
BY MR. HILDABRAND:
Q. That's fair. In general, are larger sample sizes preferred to smaller sample sizes?
MS. BROWN: Objection to form.
THE WITNESS: In the mental health literature, we often have peer-review publications that include single case studies or small case studies, ranging all the way from one individual up to large sample sizes. Thousands of people.
BY MR. HILDABRAND:
Q. Everything else being equal, would you prefer a study that had one individual case or a study that had multiple cases considered?
MS. BROWN: Again, objection to form.
THE WITNESS: It would depend on the purpose of the literature and the article I was reviewing.
BY MR. HILDABRAND:
Q. Is the study more likely to be statistically valid if it has a larger sample size or a smaller sample size?
MS. BROWN: Objection to form.
THE WITNESS: Here there may be some nuances about statistical analysis that would be

important to review with a statistician. It's very likely that in large sample sizes, for example, it's easy to find significant differences that have little meaning because there are so many people we can find information. If we're looking at hundreds of thousands of people, that would be significant.

BY MR. HILDABRAND:

Q. Thank you. Let's go to PDF page 13. Page two of your -- sorry -- page three of your CV if you want to scroll down to that. This is back in Doc A, Exhibit 1, your report.

MS. BROWN: Sorry, Clark, page two of the CV?

MR. HILDABRAND: Just one second. Page three of your CV.

THE WITNESS: Okay. We're there.

BY MR. HILDABRAND:

Q. Do you see under continuing medical education an October of 2020 presentation?

A. Yes.

Q. What's the title of that presentation listed there?

A. Path to Affirmative Medical Care for Transgender/Gender Diverse Youth: A Guide for Mental Health Provider.

Q. All right. I'm going to circulate the recording of that in just one second.

MR. HILDABRAND: This will be Doc F, and we'll enter this as Exhibit 5. This will be 5.

(WHEREUPON, a document was designated to be marked as Late-filed Exhibit Number 5, when provided.)

BY MR. HILDABRAND:

Q. Do you have that pulled up?

A. Yes.

Q. Feel free to go ahead to around the 22 second mark, 0:22. When you're there, does it say: Path to Affirmative Medical Care for Transgender/Gender Diverse (TGD Youth): A Guide for Mental Health Providers?

A. It does.

Q. And is your name listed there at the top?

A. It is.

Q. Does this appear to be the presentation that you gave back in October of 2020?

A. Yes.

Q. Okay. Now let's turn to the -- jumping ahead to the 58:22 second mark. 58:22. And if you can, please listen to 58:22 to 58:50. And when you do that, just let me know.

MS. BROWN: Clark, we're actually not getting the audio from this video and I'm sure it's a tech situation on our end. So do you want to go off the record for like five minutes so I can figure out how to get the audio to play? Or is there audio? I'm not hearing anything.

MR. HILDABRAND: Yes. There is audio. So if you want to go off the record for a minute we can sort that out. All right. Let's go off the record.

MS. BROWN: We're ready.

BY MR. HILDABRAND:

Q. All right. We are now back on the record. Before we get to the video, I'm going to read out first the website address of what was entered as Exhibit 4 and what the cumulative Exhibit 3 slides were taken from. That is https:\\www.YouTube.com\watch?v=322u6en50d8. And then I will say the website address for what has been marked Exhibit 5. That is https:\\www.YouTube.com\watch?v=HvLYai7qq0A. All right. And now --

MS. BROWN: Oh, sorry, I didn't want to interrupt. I just wanted to flag Britany on our team, you're not on mute and I saw the audio switch

to you. Okay. Thanks. You got it. Thanks.

MR. HILDABRAND: Thanks for making sure. And now the witness is going to click play around the 58:20 or 58:22 mark of the video and listen to 58:50.

THE WITNESS: Okay. Pressing play.

(Playing video.)

Our best practices are still emerging for children and adolescents. This is, you know -- what we know about therapy and mental health is done through relatively small case studies at this point in time but the literature is growing every day. We look a lot to the principles of trauma-informed care to be supportive and so leading with the individual's affirmation believing their truth and helping them to identify where the distress and the hurt is. I think --

(Stopped video.)

MS. BROWN: Okay. That's at 58:51. You're on mute again. Sorry.

BY MR. HILDABRAND:

Q. Yeah. Dr. Cyperski, was that you speaking?

A. That was me speaking as part of a one-hour presentation.

Q. Did you say that our best practices are still

emerging for children adolescents?

MS. BROWN: If you want to hear it again, it was playing very quickly, to confirm, we can do that.

THE WITNESS: Uh-huh. Uh-huh.

MS. BROWN: And I'm sorry. Will you just repeat the question and then we'll try to confirm?

BY MR. HILDABRAND:

Q. Sure. Yes. This question is, Our best practices are still emerging for children and adolescents, did you say that?

(Playing video.)

Our best practices are still emerging for children and adolescents. This is, you know, what we know about --

(Stopped video.)

BY MR. HILDABRAND:

Q. Right. So did you say that statement?

A. That statement was said again as part of context within a one-hour presentation.

Q. Do you agree that the best practices for psychological treatment of transgender children are still emerging?

MS. BROWN: Objection to form.

THE WITNESS: So this particular statement would need to be understood in context and I believe at this point in the presentation we were answering Q&A. And so would be preferable to review some more of the contents before and after that statement to inform interpretation.

BY MR. HILDABRAND:

Q. Rather than watching the whole -- the entire video, which glad at any point if you -- glad after the deposition if you want to review that or during a break. But would you agree with the statement today that best practices are still emerging for children and adolescents regarding transgender healthcare?

MS. BROWN: Objection to form.

THE WITNESS: So the question is if best practices are still emerging -- can you repeat it? I'm so sorry.

BY MR. HILDABRAND:

Q. Are best practices for transgender children, treating them for mental health, still emerging?

MS. BROWN: Same objection.

THE WITNESS: We have many established best practice guidelines such as the Endocrine Society and the WPATH. As previously provided in an

answer a few minutes ago, in all of medical sciences we are regularly updating the literature and exploring new information to keep our practice current in support of best practices.

BY MR. HILDABRAND:

Q. Did you also say that what we know about therapy and mental health is done through relatively small case studies at this point in time? And if you want to watch the video, that's fine.

A. Okay. We're going to pull up the video again.

MS. BROWN: Clark, do you have a time stamp? I know it's relatively short but...

MR. HILDABRAND: And you can start at 5:24. I'll be after that statement, the statement we discussed a minute ago.

MS. BROWN: 58:25.

THE WITNESS: Okay. Hitting play.

MS. BROWN: Oh, wait. And just to make sure, Clark, will you repeat the question?

BY MR. HILDABRAND:

Q. Did you say that what we know about therapy and mental health is done through relatively small case studies at this point in time?

(Playing video.)

What we know about therapy and mental health is done through relatively small case studies at this point in time.

(Stopped video.)

THE WITNESS: Yes. Again, that statement was made in context of a larger discussion in a one-hour presentation and is a very small snippet of which may wish to more accurately describe and articulate in another context.

BY MR. HILDABRAND:

Q. So at this point in time, two years later, would you agree that what we know about therapy and mental health is done through relatively small case studies at this point in time? And feel free to elaborate or provide further context.

MS. BROWN: Objection to form.

THE WITNESS: What we know about mental health in the transgender population is that there is a significant body of literature that identifies mental health concerns and experience in transgender children and we are ongoing working to update and advance the literature in the state of the science as is consistent with best practices across medicine and other professions.

/ /

BY MR. HILDABRAND:
Q. Are those developments done through relatively small case studies at this point in time today?
MS. BROWN: Objection to form.
THE WITNESS: I would be curious what you mean and what the definition of relatively small case studies would be.
BY MR. HILDABRAND:
Q. How would you understand that phrase, "relatively small case studies"? Do you have an understanding of what that would mean?
MS. BROWN: Same objection.
THE WITNESS: I can see several different interpretations of what relatively small case studies would mean.
BY MR. HILDABRAND:
Q. What are some of those interpretations?
A. If someone were using that phrase, it might mean that there were a small number, so a handful of case studies. It might mean that there were case studies which included a small number of participants would be another interpretation.
Q. In your practice, do you begin by believing the individual's truth about their gender identity?

MS. BROWN: Objection to form.
THE WITNESS: Can you repeat the question?
BY MR. HILDABRAND:
Q. Of course. In your practice treating transgender individuals, do you begin by believing their truth about what they express their gender identity to be?
MS. BROWN: Same objection.
THE WITNESS: It might be important to define believing their truth and the statement could be considered in the context of gender-affirming care.
BY MR. HILDABRAND:
Q. Are some children incorrect about what their gender identity is?
MS. BROWN: Objection to form.
THE WITNESS: No.
BY MR. HILDABRAND:
Q. So all children know what their gender identity is; is that your position?
MS. BROWN: Objection to form.
THE WITNESS: By definition that we established previously, individual gender identity is their own sense of self of their internal sense

of gender. So I'm having a hard time thinking through when an individual's declaration of their gender identity would ever be incorrect because it is their own understanding of their gender.

Q. Thank you. That's helpful. Let's go to your report, paragraph 14, which is on page four.

A. Okay. Page four of the report. Paragraph 14?

Q. Yes.

A. We are there.

Q. Great. Does it say that many transgender people become aware of their gender identity at a very early age? Is that what the report says?

A. That is in the report.

Q. Do you still agree with that statement today?

A. Yes.

Q. You used the phrase "at a very early age." What ages do you mean by that phrase here?

A. In the literature, there is evidence that children and people can start to become aware of their gender as young as three years old or younger. It is going to vary by individual and by their unique abilities.

Q. What is the youngest a patient has told you that they are transgender?

MS. BROWN: Objection to form.

THE WITNESS: In my clinical experience, I have heard patients and their caregivers recount that they first became aware and shared their gender identity at the age of two or three.

BY MR. HILDABRAND:

Q. Just to clarify, is that a transgender identity they shared at the age of two or three?

MS. BROWN: Objection to form.

THE WITNESS: Can you restate the question for me, please?

BY MR. HILDABRAND:

Q. Glad to. So are you aware of children ages two to three expressing a gender identity inconsistent with their sex assigned at birth?

A. Yes.

Q. Have children at the ages of two to three who have expressed a gender identity inconsistent with their sex assigned at birth been treated at VPATH?

MS. BROWN: Objection to form.

THE WITNESS: Within the VPATH Clinic, I am not aware of the specific age range for all of the patients seen by all of the providers in our clinic. So I don't know that I am aware of how to answer that question at this point.

BY MR. HILDABRAND:
Q. What's the youngest age child who expressed a gender identity inconsistent with their sex assigned at birth that you are aware being treated at VPATH?
MS. BROWN: Same objection.
THE WITNESS: I am aware of children who are probably six years old that have been -- who have met with one of the providers in our interdisciplinary clinic.
BY MR. HILDABRAND:
Q. Are you aware of children at ages five or younger who have met with professionals at VPATH?
A. It is certainly possible that children under six years old could meet with one of the professionals.
Q. But today you're not aware one way or the other?
A. I am not.
Q. All right. Going back to Exhibit 5, the YouTube video. Actually, before we do that, what percentage of children persist in their expressed transgender identity?
MS. BROWN: Objection to form.
THE WITNESS: We would need some additional context to answer that question.

BY MR. HILDABRAND:
Q. What's your estimation of the percentage of children that persist in their gender identity? And feel free to break it out if you want to between prepubertal children or children in the middle of puberty or children are teenagers who have completed puberty?
MS. BROWN: Same objection.
THE WITNESS: So the question is around individuals who persist in their gender identity. And there is a high percentage of individuals, children and adolescents who, upon sharing and discovering their gender identity, will persist in their identity.
BY MR. HILDABRAND:
Q. Let's go in the video, Exhibit 5, to the 12:15 mark. We're not going to listen to anything here. We're just going to just look at the screen if you can see that.
MS. BROWN: I'm sorry, Clark. What's the title of the video?
MR. HILDABRAND: Oh. This is the more recent one, the Path to Affirmative Medical Care for Transgender/Gender Diverse Youth.
MS. BROWN: So are we done with audio?

MR. HILDABRAND: Don't need the audio.

MS. BROWN: Okay. Well, we have it pulled up.

BY MR. HILDABRAND:

Q. In about the 12:15, 12:20 mark, the slide there.

MS. BROWN: Okay. We're at 12:16.

BY MR. HILDABRAND:

Q. Does this slide say considerations for youth?

A. Yes.

Q. Then does it say validity in prepubertal children versus adolescents?

A. It does.

Q. What percentage does it give for how children persist?

A. On this slide from, I believe it was a presentation in 2020, it says: Fluidity in prepubertal children versus adolescents and the first bullet point is children persist 12 to 27 percent.

Q. And just to be fair with you earlier, in the bottom right-hand side corner, is there anything that it looks like the slide is citing?

A. Yes, sir. There are several articles that are cited on this slide.

Q. And then going back up, does it say that adolescents near 100 percent persistence?
A. It does.
Q. In your experience as a psychologist, is it 12 to 27 percent persistence, do you find that accurate for children?
MS. BROWN: Objection to form.
THE WITNESS: In my professional practice, I find this number is significantly lower than what I have experienced in practice.
BY MR. HILDABRAND:
Q. And then for the adolescents near 100 percent persistence, is that accurate with what you've found in your practice?
MS. BROWN: Same objection.
THE WITNESS: In my professional practice adolescents have 100 percent persistence.
BY MR. HILDABRAND:
Q. Are you aware of any academic studies done of individuals who have desisted from an express transgender gender identity?
MS. BROWN: Objection to form.
THE WITNESS: Define what you mean by academic studies in this case.
/ /

BY MR. HILDABRAND:
Q. A peer-reviewed journal article, for example.
A. And the question was a peer-reviewed journal article about what?
Q. A peer-reviewed journal article about individuals who previously expressed that their gender identity was inconsistent with their sex assigned at birth but later expressed that they were incorrect and that their gender identity really was consistent with their sex assigned at birth?
MS. BROWN: Objection to form.
THE WITNESS: There has been peer-reviewed studies on a number of topics, including individuals' persistence of gender identity.
MR. HILDABRAND: Travis, can you go ahead and circulate Document K.
THE WITNESS: We have that open.
BY MR. HILDABRAND:
Q. And what is the title of this article?
A. It reads: Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition who Subsequently Detransitioned, A Survey of 100 Detransitioners by Lisa Littman.
Q. And what journal does this appear to be

published in? And --
A. This is published -- I'm sorry. Go ahead.
Q. I'm sorry, just for help, toward the top would be somewhere to look. But if you want to answer.
A. Yes. It's published in the, appears, in The Archives of Sexual Behavior, 2021.
Q. Is that a reputable journal?
MS. BROWN: Objection to form.
BY MR. HILDABRAND:
Q. In your professional experience, is this the sort of journal whose articles you might rely upon?
A. I am not familiar with the specifics of this journal. And it appears to be a publication from that journal, however.
Q. Have you read this article or heard about it before?
MS. BROWN: Objection to form.
THE WITNESS: I have read this article in the past.
BY MR. HILDABRAND:
Q. Do you remember what your impression of the article was when you read it?
MS. BROWN: Objection to form.
THE WITNESS: Is the question about when

I initially read the article?
BY MR. HILDABRAND:
Q. What's your -- do you have an opinion about this article?
MS. BROWN: Objection to form.
THE WITNESS: I would need to review the article again. It has been sometime since I last read this article.
BY MR. HILDABRAND:
Q. All right. So let's go through parts of this article and discuss.
A. Okay.
Q. I'll point you to parts of it in just one second.
MS. BROWN: Is it zoomed in enough for you?
THE WITNESS: Yeah, I can see it. Thank you.
BY MR. HILDABRAND:
Q. So under introduction, do you see the first line? Can you read that out?
A. Uh-huh. Detransition is the act of stopping or reversing a gender transition.
Q. Do you agree that that is a fair definition of the word "detransition" in this field?

MS. BROWN: Objection to form.

THE WITNESS: This is a definition of detransition and our field uses other terms to describe this phenomenon as well.

BY MR. HILDABRAND:

Q. What terms would you use to describe this phenomenon?

A. One common term that's been identified in the field is also retransition.

Q. Is detransition a term that others in your field use to describe this?

MS. BROWN: Objection to form.

THE WITNESS: Some professionals use the term "detransition".

BY MR. HILDABRAND:

Q. How many of your patients have ever detransitioned or retransitioned?

MS. BROWN: Objection to form.

THE WITNESS: We would need to define those terms of detransition or retransition to answer that question.

BY MR. HILDABRAND:

Q. How many of your -- how many of the individuals you have treated in your practice have stopped or reversed a gender transition?

MS. BROWN: Objection to form.

THE WITNESS: None of my patients have ever stopped or reversed a gender transition.

BY MR. HILDABRAND:

Q. Are you aware of any patients at VPATH who have stopped or reversed a gender transition?

MS. BROWN: Objection to form.

THE WITNESS: I am aware of one case by another provider in the Interdisciplinary Clinic of an individual who identified as retransitioning.

BY MR. HILDABRAND:

Q. Can you give me any particulars you can remember about that case without providing names of the individual?

MS. BROWN: Objection to form.

THE WITNESS: Which particulars would you be interested in?

BY MR. HILDABRAND:

Q. Sure. Have they been on puberty blockers at any point in their treatment to the best of your knowledge?

A. So the patient I am thinking of I did not have contact with. And in fact I believe they may have established care prior to the initiation of our interdisciplinary clinic at VPATH with one of our

endocrinologists. So I'm not aware of many of the details of their case.

Q. Which professional at VPATH would be aware of the details of that case?

A. I believe it was a patient of Dr. Jennifer Najjar, who is a pediatric endocrinologist.

Q. Thank you. If it's the case that that doctor handled, I'll stop asking you questions about it.

Going back up to the abstract of this. Do you see where it says that only 24 percent of respondents informed their clinicians that they had detransitioned?

A. I see that text in the abstract, yes.

Q. Do you mainly treat children and adolescents?

A. I work with children, adolescents, young adults, and their caregivers.

Q. What's the age range of patients whom you treat?

A. Are you asking about current caseload or in my practice in general?

Q. We can ask current caseload first.

A. Okay. In my current caseload, I have patients I would estimate who are seven to 22.

Q. Are most of your patients under the age of 18?

A. Many of my patients are under the age of 18. I would agree that most are, yes.
BY MR. HILDABRAND:
Q. How long have you been licensed to practice psychology in Tennessee?
A. I believe I have been licensed since 2017 in the state of Tennessee.
Q. Any states prior to that where you were licensed to practice psychology?
A. No. I was licensed as soon as I was eligible.
Q. And so that's about five years; is that correct?
A. Yes.
Q. So you have not been treating -- there is no patient you have been treating -- I'm sorry. Rephrase.
Are there any patients you are treating whom you have been treating for more than five years?
A. I have some patients in my practice that I have had a treatment relationship with since I would say the start of my predoctoral internship or the year of my predoctoral internship, which would be 2015 or 2016.
Q. So you have not been treating -- you do not

have any relationship with a patient who you been treating that's lasted more than eight years; is that correct?
A. That's correct.
Q. All right. So earlier you mentioned that you wrote a thesis that was required to receive your Master's of Science from Auburn University; is that correct?
A. Yes.
MR. HILDABRAND: Travis, can you circulate Document G. And we'll mark that as Exhibit 6.
THE REPORTER: Did we mark Exhibit K?
MR. HILDABRAND: Oh, you're right. I think that one should be marked Exhibit 6 and this will be Exhibit 7.
(WHEREUPON, documents were marked as Exhibit Numbers 6 and 7.)
BY MR. HILDABRAND:
Q. Just one second. All right. If you can see that, what is the title of this document?
A. It says Examining Executive Functioning Deficits in Juvenile Delinquents with a History of Trauma Exposure.
Q. And who is the author?

A. Myself, Melissa Cyperski.
Q. Is this the thesis you submitted for your MS?
A. It appears that way. This is the title page. We've not reviewed the full document.
Q. On the title page, does it say approved by and lists three different professors?
A. Yes.
Q. All right. Let's turn to page 20 in the PDF. This will be page 14 in the thesis pagination but it'll be page 20 in the PDF.
A. Which page on the document? We're on page 20 of the PDF, but to confirm.
Q. Page 14 in the thesis's pagination.
A. Yes.
Q. Do you see -- in the first full paragraph, do you see the line that says: Throughout their lifetime, trauma survivors of both sexes experience increased rates of new disturbance, anxiety, disordered personality, maladaptive eating and substance use, ADHD, and oppositional defiant behavior?
A. I see that sentence in the document.
Q. In that sentence, did you use the phrase "both sexes"?
A. In this document from 2012, I did use the

term "both sexes".
Q. Do you still use the phrase "both sexes" today?
MS. BROWN: Objection to form.
THE WITNESS: I would not use the terminology "both sexes" today.
BY MR. HILDABRAND:
Q. So you would not use the terminology today that you used in your MS thesis ten years ago?
MS. BROWN: Objection to form.
THE WITNESS: I would use current terminology and my understanding of the literature and the state of our science in our field in my practice today.
BY MR. HILDABRAND:
Q. So is both sexes not current terminology?
MS. BROWN: Objection to form.
THE WITNESS: It is not consistent with my current practice.
BY MR. HILDABRAND:
Q. All right. Let's go back to your report. This is Doc A, Exhibit 1. Let's go to -- it's page 21 in the PDF, page 11 in the CV.
A. Page 21 of the PDF and I believe that this is 11 of the CV. We are scrolling to confirm. Yes, we

are there.
Q. Does this list all the articles you have published?
A. It does list peer-reviewed articles that I have published, yes.
Q. Have you published any since submitting your expert report?
A. No.
MR. HILDABRAND: All right. Do y'all want to take a break here? We've been going for about an hour since then, or do you want to keep going?
MS. BROWN: We're happy to take a break.
MR. HILDABRAND: Okay. Let's go off the record, then.
(Recess observed.)
MR. HILDABRAND: So I have about three hours and 12 minutes on the record so far.
BY MR. HILDABRAND:
Q. So going back to your CV, we were just discussing this list of articles. Is the first article listed there titled: Disproportionate minority contact: Comparisons across juveniles adjudicated for sexual and non-sexual offenses? Is that the article title?

A. Yes. Yes.
Q. Does it appear that the subject of this article is the mental health of transgender adolescents or children?
MS. BROWN: Objection to form.
THE WITNESS: So I would need to review the specifics of that article.
BY MR. HILDABRAND:
Q. If you can't remember off of the top of your head, that's fine. You can't just remember right now that that's the subject of it?
A. The subject is related to the concept of disproportionate minority contacts.
Q. So the second article is: Installing trauma-informed care through the Tennessee Child Protective Services Academy.
Do you remember -- and of course feel free to say if you can't remember off the top of your head right now -- whether or not that was related to the subject of the mental health of transgender adolescents or children?
A. That paper is not related to transgender individuals.
Q. And then the third article is: Heterogeneity in male adolescents with illegal sexual behaviors:

A latent profile approach to classification. Is that the title of the article?
A. Yes.
Q. Do you recall whether or not the subject of that article is the mental health of transgender adolescents or children?
A. That article is not related to transgender children or adolescents.
Q. And then the last article here is titled: Supporting transgender/gender diverse (TGD) youth across settings in systems of care: Experiences from a pediatric interdisciplinary clinic. Is that the title of the article?
A. It is.
Q. And that would be related to the subject of the mental health in transgender adolescents or children?
A. Correct.
MR. HILDABRAND: Travis, can you circulate Document H. And we'll mark that as Exhibit 8 I believe is the number we're on.
(WHEREUPON, a document was marked as Exhibit Number 8.)
BY MR. HILDABRAND:
Q. Thank you. Dr. Cyperski, when you can see

that, what is the title of the article here?
A. We can see it. The title reads: Supporting transgender/gender diverse youth across settings and systems of care: Experiences from a pediatric interdisciplinary clinic.
Q. Does this appear to be the fourth article listed in your CV?
A. It does appear that way, yes.
Q. And who are the authors of this article?
A. Authors are Melissa Cyperski, along with Drs. Mary Romano and Cassandra Brady.
Q. And do you work with Mary Romano and Cassandra Brady at Vanderbilt University Medical Center?
A. I do.
Q. If you can remember, what is the subject of this? What is this article about?
A. From what I can recall, this article is about ways to support transgender youth across various settings and systems of care, so different ways that youth, that providers can support youth in various situations and settings in which they interact on a daily basis.
Q. And was this a peer-reviewed article?
A. It was.

Q. Did you conduct any scientific experiment --

MS. BROWN: Objection to form.

BY MR. HILDABRAND:

Q. -- in providing this article?

MS. BROWN: Same objection.

THE WITNESS: Have I conducted scientific experiments before writing this article? Yes.

BY MR. HILDABRAND:

Q. Did you conduct a scientific experiment to contribute to writing this article?

A. Scientific experimentation was not a part of writing this article.

Q. Thank you for clarifying. So there wasn't -- this article doesn't involve a control and experiment group?

MS. BROWN: Objection to form.

THE WITNESS: There is no control or experiment group in this paper.

BY MR. HILDABRAND:

Q. All right. Was there any statistical -- original statistical analysis conducted in this article?

MS. BROWN: Objection to form.

THE WITNESS: This paper does not

include original statistical analysis.
BY MR. HILDABRAND:
Q. Does this article reflect your opinion at the time, along with the opinions of the other authors listed?
MS. BROWN: Objection to form.
THE WITNESS: This article reflects our experiences and practices and recommendations at the time.
BY MR. HILDABRAND:
Q. So on PDF page one, the first page here, Journal page 242, in the middle column, can you read the first two sentences here, starting with therefore?
A. I'm not seeing. At the top of the second column?
Q. Do you see a therefore, the purpose of this paper is?
A. Yes.
Q. Do you mind reading that sentence and then the sentence that follows it?
A. Sure. Therefore, the purpose of this paper is to outline several possible opportunities for mental providers or other healthcare professionals to advocate for transgender and gender diverse

patients, TGD patients, in order to address their psychosocial needs, enhance health outcomes, and promote resiliency across setting. Do you want me to continue?

Q. If you want to finish the second sentence. Sorry about that.

A. Do you want me to read the second sentence, too?

Q. Yes.

A. Okay. We hope to highlight various strategies or actions providers can take as needed to support patients and their families on an individual, community, or systemic scale.

Q. Was a purpose of this paper to encourage advocacy by mental health professionals?

MS. BROWN: Object to form.

THE WITNESS: Define what you mean by advocacy.

BY MR. HILDABRAND:

Q. How do you understand the word "advocacy" as used in this paper?

A. I would need to review this paper more specifically.

Q. Okay. We'll do that. Let's look at the left-hand column here.

A. Okay.
Q. Do you see about halfway down, where you describe studies about how transgender individuals are more likely to consider suicide?
A. I believe I know where you're looking.
Q. Is it consistent with your experience and practice that transgender individuals are more likely to consider suicide?
MS. BROWN: Objection to form.
THE WITNESS: The question of comparison, more likely than what?
BY MR. HILDABRAND:
Q. More likely than, for example, cisgender individuals?
MS. BROWN: Objection to form.
THE WITNESS: Can you restate the question for me, please?
BY MR. HILDABRAND:
Q. Of course. Is it your experience and practice that transgender individuals are more likely to consider suicide than cisgender individuals are?
MS. BROWN: Same objection.
THE WITNESS: There is a body of evidence which suggests that transgender individuals

may have higher percentages of suicidality or suicide attempts when compared to their cisgender peers.

BY MR. HILDABRAND:

Q. I know it's a weighty subject, but have any of your patients ever attempted suicide?

A. Unfortunately, I have had patients who have attempted suicide in the past, yes.

Q. Have any attempted suicide after beginning a patient-provider relationship with you?

MS. BROWN: Object to form.

THE WITNESS: Individuals have attempted suicide after establishing a therapeutic relationship with me as their provider.

BY MR. HILDABRAND:

Q. About how many patients in that category have attempted suicide?

A. I can think of two individuals who have attempted suicide.

Q. Toward the bottom of the left column, do you see where you say that healthcare professionals and mental health counselors in particular are in a unique position to recognize, respond to, and advocate for the multifarious and complex needs of TGD youth? Do you see that?

A. I do.
Q. Just to clarify, what are TGD youth?
A. TGD stands for transgender or gender diverse.
Q. Are there other individuals in the gender diverse category who are not transgender?
MS. BROWN: Object to form.
THE WITNESS: There are individuals who identify as gender diverse.
BY MR. HILDABRAND:
Q. Who would not identify as transgender?
A. There are individuals who identify as various gender identities which are broadly conceptualized as gender diverse that do not specifically identify as transgender.
Q. Thank you.
A. Uh-huh.
Q. Then here I think you mention that: However, professionals may hesitate to step into the role of patient advocate for a variety of reasons, including a lack of awareness about appropriate resources for SGN patients and fear of overstepping their boundaries as a provider or operating outside the bounds of their competence, even if they feel strongly about the cost. Is that what the authors wrote here?

A. Yes. That's in the text.
Q. Is this a valid concern for health professionals to be hesitant about engaging in advocacy?
MS. BROWN: Object to form.
THE WITNESS: I'm not sure what is meant by valid concerns.
BY MR. HILDABRAND:
Q. Is it acceptable for health professionals to hesitate or not step into the role of patient advocate?
MS. BROWN: Same objection.
THE WITNESS: Acceptable would be a matter of personal preference and attitude.
BY MR. HILDABRAND:
Q. So some health professionals may have personal preferences not to step into the role of patient advocate; is that correct?
MS. BROWN: Same objection.
THE WITNESS: Some professionals may hesitate for various reasons to step into a role of advocate for their patient.
BY MR. HILDABRAND:
Q. Is it unprofessional for a health professional to decide not to step into the role of

a patient advocate?

MS. BROWN: Objection to form.

THE WITNESS: I think we would need to define what patient advocate means or what the term "advocate" means.

BY MR. HILDABRAND:

Q. How did you understand the term "patient advocate" as it's used here?

A. Uh-huh. So my impression of the term "patient advocate", as represented in this article, would be professional who is acting or seeking in the best interest of their patient and seeking to ensure that their patient is getting the care that they need.

Q. Does that include speaking to individuals other than the patient?

MS. BROWN: Objection to form.

THE WITNESS: In what way?

BY MR. HILDABRAND:

Q. Would that include speaking to elected officials?

MS. BROWN: Objection the form.

THE WITNESS: It would be a question of what role that professional was playing in various behaviors.

BY MR. HILDABRAND:
Q. Is it normal for psychologists to discuss transgender medicine with elected officials?
MS. BROWN: Objection to form.
THE WITNESS: Define what you mean by normal.
BY MR. HILDABRAND:
Q. In your professional expertise and experience, is it often the case that psychologists are expected as part of being a psychologist to discuss transgender medicine issues with elected officials?
MS. BROWN: Same objection.
THE WITNESS: So the American Psychological Association, for example, has information about professional roles and responsibilities and would be perhaps one governing body that might be able to answer the question related to the role of a psychologist in this manner.
BY MR. HILDABRAND:
Q. Is it an appropriate role of psychologists to tell politicians what laws to pass or not to pass?
MS. BROWN: Objection to form.
THE WITNESS: It would be an appropriate

role for a psychologist or mental health professional to have conversations and to provide information that may inform practices that I would say, that impact truly their patient population.

BY MR. HILDABRAND:

Q. Do you consider that provision of information to elected officials advocacy?

MS. BROWN: Objection to form.

THE WITNESS: It would, again, be a question of the definition of advocacy.

BY MR. HILDABRAND:

Q. Would that be part of your definition of advocacy is the question, the provision of information to elected officials on transgender medicine?

MS. BROWN: Objection to form.

THE WITNESS: I think there are many possible definitions and as we said advocacy may take shape.

BY MR. HILDABRAND:

Q. Would you understand that under your definition of advocacy to include discussing laws relating to transgender medicine with elected officials? Is that according to your definition of advocacy, advocacy?

MS. BROWN: Same objection.

THE WITNESS: Informing legislation that benefit or harm an individual and the patient population may be a role of a psychologist in terms of protecting the wellbeing of their patient population and advocating or truly supporting rather than advocating the needs and wellbeing of their patients.

BY MR. HILDABRAND:

Q. Let's turn to the upper right-hand column in the first full paragraph here.

Do you see where it says: For example, imagine you are working with a student who identifies as nonbinary and is repeatedly misgendered with consistent incorrect pronoun usage by one of their teachers. As the provider, you offer to reach out to their teacher to express your concerns and request they change their classroom behavior to become more affirming but the patient declines and indicates they would like to talk with their teacher independently first.

Is a psychologist talking with a patient's teacher advocacy?

MS. BROWN: Objection to form.

/ /

BY MR. HILDABRAND:
Q. Sorry. To clarify, is a psychologist talking with a patient's teacher about the usage of pronouns advocacy?
MS. BROWN: Same objection.
THE WITNESS: I think the psychologist talking with a patient's teacher about any of their mental health needs, including about the possibility and importance of using that individual's pronouns, is within the role of a psychologist to speak to the wellbeing and needs of their client.
BY MR. HILDABRAND:
Q. Including if the psychologist feels it necessary, the teacher's use of what the psychologist used as incorrect pronouns, correct?
A. The use of incorrect pronouns has been widely established in the literature as a harmful, destructing experience for transgender individuals. And so as a psychologist and mental health provider, it might be important to collaborate with a patient around their needs in the school setting and then to discuss what would be supportive of their mental health and reducing or eliminating their distress at school.
BY MR. HILDABRAND:

Q. What are the correct pronouns to use for a nonbinary student?

MS. BROWN: Objection to form.

THE WITNESS: Pronouns vary by individuals. It would be important to collaborate and discuss with each individual what were their pronouns.

BY MR. HILDABRAND:

Q. Could they include pronouns other than he/him or she/her?

A. They could.

Q. Could they include pronoun such as they/them to refer to an individual student?

A. It might, yes.

Q. Could they include pronouns other than the ones we just discussed to refer to that student?

A. Yes, it could.

Q. What should a psychologist do if the teacher says that she does not want to use what she used as biologically inaccurate pronouns?

MS. BROWN: Object to form. Sorry.

BY MR. HILDABRAND:

Q. Should the teacher -- should the psychologist still recommend that the teacher use the pronouns the teacher views as biologically inaccurate?

MS. BROWN: Same objection.

THE WITNESS: I don't understand what's meant by biologically accurate or inaccurate pronouns.

BY MR. HILDABRAND:

Q. Sure. I'll explain. So imagine that there were a child whose sex assigned at birth is female but the child identifies as nonbinary and prefers the pronouns they/them. If the teacher says that she will only use she/her pronouns to refer to the student, is that incorrect of a teacher to do so?

MS. BROWN: Object to form.

THE WITNESS: For an individual who has expressed that they do they/them pronouns, those would ideally be the pronouns that are used for that individual across settings. Use of other pronouns, and particularly use of pronouns consistent with their sex assigned at birth, have been demonstrated to be damaging to that individual's mental health and may worsen experiences of gender dysphoria.

BY MR. HILDABRAND:

Q. Could it damage the mental health of the teacher if she were forced to use the they/them pronouns in that scenario?

MS. BROWN: Object to form. And scope.

THE WITNESS: I would be curious what you mean by damage the teacher's mental health.
BY MR. HILDABRAND:
Q. So you said it can be hurtful to the student for the teacher to fail to use the pronouns the student prefers. But what about the teacher? Could it be harmful to a teacher to be forced to use pronouns that do not match the child's sex assigned at birth?
MS. BROWN: Same objection. Scope.
THE WITNESS: So my practice tends to focus on children and adolescents and young adults. I have not evaluated teachers in this particular instance who may have this experience.
BY MR. HILDABRAND:
Q. So you would not be able to offer an expert opinion about the mental health of the teachers?
MS. BROWN: Objection to form.
THE WITNESS: It is not within the scope of the expert report I offered.
BY MR. HILDABRAND:
Q. Thank you. Also on here it describes role-playing sessions with nonbinary or transgender students to prepare for having those discussions with teachers.

Have you engaged in role-playing sessions with nonbinary or transgender patients before they discuss the issue of the use of pronouns with teachers or family?

MS. BROWN: Objection to form.

THE WITNESS: Can you repeat the specific question for me?

BY MR. HILDABRAND:

Q. Have you engaged in role-playing sessions of the sort described here in the right column that you recommend for psychologists to do? Have you engaged in such role-playing discussions with students about playing through the student, the transgender and nonbinary student, discussing with the teacher or a parent the pronouns that the student prefers?

A. The use of role play is a common activity in child and adolescent mental health and I -- from what I can recall, I have engaged in role play with transgender or nonbinary individuals.

BY MR. HILDABRAND:

Q. Is that something that insurance companies would reimburse your time for?

MS. BROWN: Objection to form, and objection to scope.

THE WITNESS: So I do not know the ins

and outs of billing. But, yes, my understanding is that that is a common and respected practice in psychotherapy to engage in interpersonal role play, and I have no evidence to suggest that it is not reimbursable.

BY MR. HILDABRAND:

Q. I won't go into billing practices, but are any of your patients on Medicaid?

MS. BROWN: Objection to scope. This is like nothing that -- like at all relevant.

MR. HILDABRAND: Again, if you have an objection, you can note objection to form, objection to scope, but not speaking objections.

BY MR. HILDABRAND:

Q. Can you please answer my question?

MS. BROWN: I'm going to be very clear that it's my right and I will speak and so I would appreciate if you didn't say that again. I'm not going to go back and forth with you but it's the right under the case law and the rules. So, again, the objection stands. You can continue to ask your question.

MR. HILDABRAND: Yes. And also in the case law not to give speaking objections.

/ /

BY MR. HILDABRAND:
Q. Can you please answer the question. Are any of your patients on Medicaid?
MS. BROWN: Same objection. Scope. Relevance.
THE WITNESS: Many of my psychotherapy clients have commercial insurance. Patients in the VPATH Clinic have TennCare, which I believe would be consistent with medicaid.
BY MR. HILDABRAND:
Q. All right. Thank you. Now, let's go to PDF page two. This is page 243 in the article, left column. Can you see the paragraph that starts, for example?
A. I believe so, yes.
Q. And so it says here: For example, consider the case of a transgender adolescent male who is forbidden by his high school to participate in extracurricular activities in his affirmed gender.
Was that a case that one of the authors of this article encountered?
A. We have many cases of individuals who may be forbidden from participating in activities in their affirmed gender. And as far as this scenario was based on a particular case, yes.

Q. Was it based on one of your patient's case or if you can remember?
A. I would need to review the example to be certain.
Q. So it goes on to say: Therefore, upon obtaining consent from a patient, his healthcare provider advocated directly on his behalf by expressing concern to school administrators in a letter of support.
If you can remember, who was the healthcare provider who advocated directly?
A. Review of the additional context in this paragraph, the information above that sentence, I believe this particular paragraph is about a patient of mine, although many of the providers in our Interdisciplinary Clinic also write letters of support.
Q. So is that patient at a school in Tennessee?
A. I'm trying to recall which patient this may have been specifically. Many of my patients are in Tennessee. Clinic also supports patients in other surrounding states as well.
Q. And if you can't remember, that's fine, and we can move on. But do you recall at this point in time?

A. I -- I think I am remembering the patient. And, yes, it was a student in Tennessee.
Q. All right. Continuing in the middle column here.
A. Uh-huh.
Q. Do you see where: As is to be expected, sociopolitical factors often dictate the extent to which the school system may be able to accommodate requests and adapt their policies? It goes on, and feel free to read the rest of the sentence if you want to.
But what did you mean here by sociopolitical factors?
A. My interpretation of sociopolitical factors in this context in this paragraph and in the article could be referring to a number of things, but would include correct legislation.
Q. What sort of legislation? Is that what you said?
A. Uh-huh.
Q. Do you mean like the legislation in this case or is there other legislation that you have in mind?
MS. BROWN: Objection to form.
THE WITNESS: It may be legislation such as in this case or legislation pertaining to other

transgender-related concerns.
BY MR. HILDABRAND:
Q. So the sentence goes on to say: However, it has been our experience that educational staff members will hear and respond to individual requests to the extent possible.
Has that been your experience here in Tennessee?
A. I have experienced many educators to be responsive and kind but not all.
Q. Going down this column, it describes -- and feel free to read it if you want to. Going down the column and on to the right-hand side here, that column, it describes compromises that are sometimes reached with other members of the extracurricular activities. For example, I believe here the school district may agree that an individual youth can be offered the opportunity to participate in extracurricular activities in their affirmed gender if the parents of other team members agree and offer a statement of support.
Is that a compromise that you have been aware has been reached here in Tennessee at any point in time?
MS. BROWN: Object to the form.

THE WITNESS: What would be the specific compromise in question, again?

BY MR. HILDABRAND:

Q. Asking other parents if they'd consent to having the transgender individual play on the sports team that he or she prefers?

MS. BROWN: Object to form.

THE WITNESS: I'm sorry, I think I got lost. So a question about asking other parents -- can you repeat it one more time for me? I'm so sorry.

BY MR. HILDABRAND:

Q. No. It's been a long day. So this describes a compromise where other parents on the team are asked whether or not they would consent to an individual who wants to play on the team that matches their gender identity would consent to that individual playing on the team. Is that a compromise that you are aware any team in Tennessee has reached in the past few years?

A. So if I am reading correctly, I'm not seeing specifically related to this instance of a team, although it may be reflective of an athletic policy and submitting that language in the report, but that -- let's see. I'm reading again.

Q. I guess it refers to extracurricular activity. Is that the language that it uses?
A. Yes. Extracurricular activities in their affirmed gender. And then I could see if other team members. Uh-huh.
Q. Is there a compromise that you're aware has been reached at any point in Tennessee?
A. I am not aware of that particular compromise being reached in Tennessee. I think the case in question, if I'm recalling correctly, was about an individual who wished to go on an overnight band trip.
Q. Thank you. All right. Let's turn to page three in the PDF, page 244 in the Journal. I'll go to the top left column.
A. Page three of the PDF, top left. Okay.
Q. And then let's go to the first full paragraph. Do you see where it says: Consider the case of?
A. Yes.
Q. So it says: Consider the case of the TGD adolescent who experienced bullying when using the restroom associated with their affirmed gender at school. Is that what the first line here says?
A. Yes.

Q. And feel free to read through silently if you want to the rest of the paragraph. But does it say at the end that -- just one second. Sorry. The next paragraph begins: The school system was initially frustrated and resisting to making such accommodations as they believe they had already provided reasonable accommodation. However, they were ultimately swayed by persistent advocacy and articulation of the patient's need in a sensitive matter. Do you see that?

A. I see that statement, yes.

Q. Does this describe a case where you advocated on behalf of the patient or one of the other authors advocated on behalf of the patient?

A. I'm not certain. I'm not recalling this particular case in my own practice.

Q. Then about midway down through that paragraph, do you see where it says: Although the provider was singularly focused in advocating for the youth's right and need to feel comfortable and safe using the restroom of their choosing. He goes on to describe the presentation of this information was balanced and validated the school's concerns.

Is it appropriate for a professional to be singularly focused only on the individual patient's

rights when doing this sort of advocacy?

MS. BROWN: Objection to form.

THE WITNESS: I'm not sure what you mean. Can you restate the question, please?

BY MR. HILDABRAND:

Q. So when a provider is doing advocacy about bathroom use for transgender or nonbinary youth, is it acceptable, professionally acceptable for the provider to be singularly focused only on the patient's interest?

MS. BROWN: Objection to form, scope, and relevance.

THE WITNESS: I think it can be very important for a healthcare professional to be focused in what are the needs of their patient that would support their health and wellbeing.

BY MR. HILDABRAND:

Q. Is that the only interest a psychologist should consider?

MS. BROWN: Object to the form.

THE WITNESS: What other interests would we be considering?

BY MR. HILDABRAND:

Q. That's my question. What other interests should the psychologist consider?

MS. BROWN: Same objection.

THE WITNESS: So the question is what are other interests a psychologist should consider?

BY MR. HILDABRAND:

Q. Before engaging in this advocacy, are there any other interests the psychologist should consider?

MS. BROWN: Same objection.

THE WITNESS: I think it would be appropriate for a psychologist, mental health provider or other healthcare professional, to be focused on their patient's needs and what supports their health and wellbeing.

BY MR. HILDABRAND:

Q. Anything else that they should be focused on?

MS. BROWN: Same objection.

THE WITNESS: I think it would depend and there are probably lots of other things that providers could focus on. But that is an organizing principle in much of the work that we do is to promote health and wellbeing in our patients.

BY MR. HILDABRAND:

Q. All right. Turn to the right column. Do you see the paragraph that begins, data are lacking?

A. Toward the bottom of the page? Yes, I am

seeing that.
Q. So does it read: Data are lacking but anecdotally parental responses to their SGM youth are often affected by factors such as culture, socioeconomic status, and religious beliefs? Has that been your experience and practice?
A. My experience has been that parental responses vary and can be influenced by a variety of factors, including but not limited to those that are listed.
Q. How should a psychologist respond when the child expresses a gender identity inconsistent with the child's sex assigned at birth but the parents disagree and say that the child is not transgender? What should a psychologist do?
MS. BROWN: Objection to form.
THE WITNESS: The question is about an individual child or adolescent who has a gender identity incongruent with their sex assigned at birth and the parents are not supportive? Is that right?
BY MR. HILDABRAND:
Q. And the parents do not agree that the child is transgender, should the child still be treated as transgender?

MS. BROWN: Same objection.
THE WITNESS: So in the psychologist's practice, we would really look to the best practice guidelines, including the WPATH and the Endocrine Society to help us navigate complex individualized patient situations. We would collaborate with the youth and their caregiver to determine an appropriate course of action that really promotes the health and wellbeing of that individual patient.
BY MR. HILDABRAND:
Q. Have you ever treated a patient as transgender where the parents disagree about whether the child is transgender?
MS. BROWN: Objection to form.
THE WITNESS: I have worked with individuals who identified as transgender and parents were not supportive of their child's gender identity.
BY MR. HILDABRAND:
Q. When you say not supportive, do you mean that the parents do not agree that the child was transgender?
MS. BROWN: Object to the form.
THE WITNESS: I am not sure about parents' agreement with whether the child is

transgender or not. But I do recall consents where their caregivers were not supportive of their identity and exhibited behaviors accordingly, including not using their child's name and pronoun, which has been largely demonstrated in the literature as important to the health and wellbeing of the transgender individual.

BY MR. HILDABRAND:

Q. So was it psychologically -- in your opinion, in those cases where the parents refused to use the child's preferred pronoun, did that cause psychological harm to the patient?

MS. BROWN: Object to form.

THE WITNESS: I think the term "psychological harm" would be complicated and we would want to break that down further. It is very potentially damaging and distracting to an individual child when their parents and others do not use their name and pronouns.

BY MR. HILDABRAND:

Q. So in your experience as a psychologist, it can be damaging to the child if the parent declines to use the child's preferred pronouns?

A. Yes.

Q. Should parents make the final decision about

how to treat children in adolescence who have expressed a transgender gender identity?

MS. BROWN: Object to form.

BY MR. HILDABRAND:

Q. Let me rephrase. Should parents make the final decision about how to treat children in adolescence who have expressed that their gender identity is inconsistent with their sex assigned at birth?

MS. BROWN: Same objection.

THE WITNESS: I think the decisions about how to treat the child who has expressed their gender identity is different from or incongruent with their sex assigned at birth, decisions about how to move forward are -- that information is really informed by the guidelines, such as in the WPATH, in which we are striving to work together and that a mental health provider, for example, would be collaborating with that patient and their caregiver to develop a treatment plan and to work towards what would promote health and resiliency for that individual.

BY MR. HILDABRAND:

Q. I understand it would be complex. You might want to discuss -- provide your opinion and discuss

that with the patient and the parents. But at the end of the day, who makes the final decision about how to treat a minor child? Is it the patient child? Is it the psychologist or other health provider? Or is it the parents?

MS. BROWN: Again, objection to form.

THE WITNESS: I think in the field of child development and for the cisgender and gender diverse individuals, for all people and all children, right, but ideally the treatment of the child is made collaboratively with that child's wishes and voice as a part of the discussion.

BY MR. HILDABRAND:

Q. So is it your opinion that even in situations where laws do not dictate a treatment one way or the other, parents are not the final decision maker for health decisions for minor transgender children and adolescents?

MS. BROWN: Objection to form.

THE WITNESS: Is the question about who makes medical decisions?

BY MR. HILDABRAND:

Q. Who is the final decision maker? Is it the parents?

A. I'm not sure what final decision maker means.

In our practice and my clinical experience, those decisions around patient care are made collaboratively between the patient, their legal guardian, and their treatment team.

Q. Okay. So to give an example, if you recommend that a patient start hormone therapy, the patient/minor child would like to start hormone therapy but the parents say no. Do the parents get to make that decision and not start hormone therapy for their minor child?

MS. BROWN: Object to form.

THE WITNESS: In our practice, legal guardian consent is required to begin a course of treatment.

BY MR. HILDABRAND:

Q. So VPATH would not start a course of treatment like that without receiving parental or other legal guardian permission, correct?

A. What treatment specifically?

Q. Hormone therapy is the example we were using in our discussion, I think.

A. Thanks for the reminder. I appreciate it. VPATH would not initiate hormone therapy without legal guardian consent.

Q. On PDF page four, Journal page 260 -- or 245,

let's turn there. It mentions the Trans Buddy Program down here in the right column, the bottom right of the column, around the middle of the page.

A. Yes, I see it.

Q. Can you describe what the Trans Buddy Program is?

A. Sure. So I am not affiliated with that program. I'll do my best to describe what I understand it to be. The Trans Buddy Program is a part of the program for LGBTQ Health at Vanderbilt University Medical Center. And the trans study program includes a trained volunteer who can serve as a patient and guardian's request for a variety of reasons, from initiating appointments at the medical center, all the way through conclusion of the visits and receiving support thereafter.

Q. Do any of your patients have a trans buddy assigned to them?

A. I don't know that trans buddies are assigned, per se, to follow an individual over time. Patients in my clinic in VPATH have relied on support from a trans buddy in the past.

Q. Other than cases such as child abuse by a parent, are parents given access to all of their minor children's medical information at Vanderbilt

University Medical Center that you're aware of?

MS. BROWN: Object to form.

THE WITNESS: So I'm not sure of all the ins and outs of when parents are given access to the records for children and adolescents. They are, I believe, provided the option and information about the pathways to receive all of that information.

BY MR. HILDABRAND:

Q. Have you heard the phrase -- do you know what My Health at Vanderbilt is, or MHAV?

A. I do.

Q. What a My Health at Vanderbilt account would be?

A. Yes. Sorry to interrupt.

Q. Sorry to interrupt you as well. Can you just explain what your understanding of that would be?

A. Uh-huh. My Health at Vanderbilt is a patient portal consistent with my chart, which is a common practice for medical systems across the country. And it allows access to communicate with your provider, to schedule appointments, to pay your bill, to navigate all of your experiences in the Medical Center.

MR. HILDABRAND: Travis, can you circulate what I believe is Document J, VUMC Website

Parental Access.

THE WITNESS: I think it might be in the chat. And if we could take a break in a few minutes, that might be great.

MR. HILDABRAND: If you want to take a break, now is fine with me if you want to take a break. Would you like --

MS. BROWN: Sure. Let's say ten minutes.

THE WITNESS: Thank you.

(Recess observed.)

MR. HILDABRAND: Let's go back on the record. I have four hours and five minutes is what we have spent on the record so far.

BY MR. HILDABRAND:

Q. So let's go back to the document circulated as Doc J, which we will enter as Exhibit 9.

(WHEREUPON, a document was marked as Exhibit Number 9.)

BY MR. HILDABRAND:

Q. Dr. Cyperski, does this appear to be a screen capture from a Vanderbilt University Medical Center website?

A. It looks consistent with the website, yes.

Q. So going down to the bottom of PDF page one,

sorry -- going down to -- going down to page -- PDF page two, do you see where it says, Children age 13 to 17?

A. Yes, I see that.

Q. So does it say there: If your child is between the ages of 13 to 17 and you need to obtain My Health at Vanderbilt access follow these steps. If you are the biological parent, you can complete the application at the child's next appointment or download and complete the form below. My Health at Vanderbilt Account Access for Children 13 to 17. Bring it with you to the child's next appointment or visit the nearest Vanderbilt walk-in clinic as your government issued photo ID has to be verified. Ensure your child signs the application as well. Did I read that accurately?

A. Yes.

Q. And then does it say: Access to My Health at Vanderbilt can be granted within the clinic once the application is turned into the clinic staff? Did I read that accurately?

A. That's what it says.

Q. Has one of your patients or their parents ever provided to you with this form?

A. I have not received this form. This type of

administrative work is often handled at the front desk.

Q. Does it appear from this website that without this form parents would not have access to a child age 13 to 17 to their data on My Health at Vanderbilt?

MS. BROWN: Objection to form. Objection to scope. Objection to relevance.

THE WITNESS: It appears as though this website is describing how parents can gain access to My Health at Vanderbilt for children 13 to 17.

MR. HILDABRAND: Travis, can you circulate Doc I. So this would be Exhibit 10.

(WHEREUPON, a document was marked as Exhibit Number 10.)

BY MR. HILDABRAND:

Q. Dr. Cyperski, can you read to me, at the top of this, does it say: Vanderbilt University Medical Center Parental Access to the My Health at Vanderbilt, MHAV, account of a teen 13 to 17 years old? Is that what it says at the top of the first page?

A. It does say that.

Q. And turn to page two of this document. Do you see about a little less than midway down, where

it says: I understand that I may revoke this access at any time by asking my doctor to do so? Is that what it says here?
A. I see that in the text, yes.
Q. And a few lines above, does it say: Teen's agreement?
A. Yes.
Q. Have you ever seen this form before or a completed version of this form before?
A. I have not.
Q. For any of the patients that you treat, are legal guardian parents not granted access to their My Health at Vanderbilt accounts?
MS. BROWN: Objection to form. Objection to relevance. Objection to scope.
THE WITNESS: For the patients in my practice, I am not aware of patients who do not have parents or legal guardian access to My Health at Vanderbilt unless they are adults.
MR. HILDABRAND: Let's return to -- before I return, though, for opposing counsel, objection to form, relevance, and scope, do you understand relevance and scope to be outside of objection to form?
MS. BROWN: I am preserving the

objections that I want to preserve. And yes, I do understand this to be outside of the objection to form.

MR. HILDABRAND: So unless you say relevance and scope, you have not objected to relevance and scope? Is that your understanding?

MS. BROWN: Again, I'm going to make the objections I'm going to make and that's all that I can -- I can say any further, Clark.

MR. HILDABRAND: I understand. But if you're -- please keep your objections short. If you don't think that form covers relevance and scope, of course do so. It's common practice for form to cover both of those. So by using additional language beyond that, my concern is that you are coaching the witness. And so if you really think that those are outside of objection to form then of course you can use those. But if you think those are covered by objection to form, then please leave your objection to objection to form.

MS. BROWN: Again, I'm going to make the objections I'm going to make. As an attorney I would never coach my client and, again, I understand them to be especially in this context of this case and this witness, to be exactly the objections that

I have made. But I have noted your concerns and they are on the record. Thank you.

MR. HILDABRAND: Thank you. I'll understand that there are additionals there.

BY MR. HILDABRAND:

Q. All right. Let's go back to the Journal, PDF page five, Journal page 246. And just to clarify, I think this was Document H. Do you see in the bottom left column where it says: Providers who are interested in offering high quality care to TGD youth are encouraged to be aware that they will be called to go above and beyond for their patients by promoting wellness and supporting collaboration, coordination, or continuity of care outside the standard appointment time. Is that what it says there?

A. It does, yes.

Q. So is it common for psychologists to treat their patients outside the standard appointment time?

A. It was standard practice. There are a variety of activities that require completion outside of the standard appointment time.

Q. And top of the middle column, do you see the sentence that says: Therefore, providers can play

an important role in advocating at the state and federal level for legislation that honors, protects, and serves the SGM community? Is that what you wrote?
A. I see that statement, yes.
Q. Do you offer any expert testimony about what legislation that honors, protects, and serves the SGM community is?
MS. BROWN: Objection to form.
THE WITNESS: Testimony in what context?
BY MR. HILDABRAND:
Q. In this case, in your report?
MS. BROWN: Same objection.
THE WITNESS: Can you repeat the question for me?
BY MR. HILDABRAND:
Q. Yes. So you used the phrase in this article, advocating at the state and federal level for legislation that honors, protects, and serves the SGM community. Do you provide --
A. Uh-huh.
Q. Do you provide any expert testimony about what such legislation is or is not?
MS. BROWN: Objection to form.
THE WITNESS: I provide an opinion and

information in the report around the legislation in question in this case and practices that honor, protect, and serve the SGM community, which would include transgender individuals.

BY MR. HILDABRAND:

Q. So in the next paragraph, middle column, I believe you -- do you specifically cite legislation proposed by the Tennessee State Legislature in 2020? Do you see that?

A. I do.

Q. And you say that these healthcare professionals collaborated with community agencies, legal experts, and lobbyists to draft expert testimony to be presented to legislators; is that correct?

A. I see that healthcare professionals collaborated with community agencies, legal experts, and lobbyists, yes.

Q. Did you draft expert testimony to present to legislators regarding this 2020 legislation?

MS. BROWN: Object to form.

THE WITNESS: I drafted expert testimony.

BY MR. HILDABRAND:

Q. What expert testimony -- what legislation was

that expert testimony about?
A. I did not end up providing expert testimony in 2020 but my colleagues in the Interdisciplinary Clinic have.
Q. So you yourself did not draft expert testimony about 2020 legislation; is that correct?
A. I drafted testimony.
Q. Yes. So what legislation did you draft testimony about?
A. I drafted testimony about the legislation that would prevent prescribing hormones to prepubertal children. I am forgetting the specific number to the legislation.
BY MR. HILDABRAND:
Q. Was your draft for or against the legislation?
A. It was against the legislation.
Q. Did you send this draft to anyone?
A. I do not recall specifically, although it is possible we were collaborating with lobbyists and experts at Vanderbilt Medical Center. And so it is possible that I shared a draft with them.
Q. Which lobbyists were you collaborating with?
A. Forgive me, I'm trying to recall. So we partnered with professionals at Vanderbilt

University Medical Center, as well as lobbyists with Emap, whose name I believe was Jim Schmidt (phonetic) and his company.

Q. And have they requested that you draft this or is that something you just decided to do yourself?

A. I don't recall the specifics.

Q. Did that legislation that you had drafted, a document in opposition to, did it pass the Tennessee Legislature?

A. It did.

Q. Have you pinned any op ed pieces opposing pieces of Tennessee legislation?

MS. BROWN: Object to form.

THE WITNESS: I have not.

BY MR. HILDABRAND:

Q. Have you posted commentaries on social media about Tennessee legislation?

MS. BROWN: Object to form. And objection to scope.

THE WITNESS: Not that I recall.

BY MR. HILDABRAND:

Q. Have you signed any petitions about Tennessee legislation?

MS. BROWN: Same objections.

THE WITNESS: I do not recall about Tennessee specific legislation.

BY MR. HILDABRAND:

Q. Did you advocate for or against the legislation challenged in this case before its passage?

MS. BROWN: Object to the form.

THE WITNESS: I do not recall.

BY MR. HILDABRAND:

Q. Are there any other legislation in Tennessee or outside of Tennessee that you have advocated for or against because you are a psychologist?

MS. BROWN: Objection to form. Objection to scope. And objection to relevance.

THE WITNESS: I along with members of the medical community may have signed petitions that were not in support of legislation that targeted the transgender community.

BY MR. HILDABRAND:

Q. Targeted the transgender community in what ways, if you can remember?

A. I suspect that there may have been petitions against healthcare bills that would be banning affirmative care for transgender individuals --

/ /

BY MR. HILDABRAND:
Q. What sorts of care --
A. -- or other --
Q. Sorry.
A. No. Or other concerns may also have been represented. I'm not sure.
Q. What sorts of affirmative care are you talking, just because that can mean a broad category? Do you mean hormone therapy?
A. Affirmative care -- uh-huh. I'm sorry?
Q. Would hormone therapy be included in the category of affirmative care you mentioned?
A. Hormone therapy is one of many components of affirmative care.
Q. Are you concerned that it might weaken societal respect for psychologists or other mental health providers if they engaged in such advocacy?
MS. BROWN: Objection to form.
THE WITNESS: The question is about weakening public respect?
BY MR. HILDABRAND:
Q. Yes.
A. Okay. No, I'm not concerned that -- that psychologists speaking on behalf of their patient means would generate disrespect for mental health

professionals.
Q. Do you have any other concerns about psychologists engaging in that sort of advocacy?
MS. BROWN: Objection to form.
THE WITNESS: There are other concerns about engaging in speaking on behalf of patients, including fear potentially of being targeted or harassed by the public.
BY MR. HILDABRAND:
Q. So the concerns are more about the public targeting or harassing psychologists; is that correct?
MR. HILDABRAND: Objection to form.
THE WITNESS: Yes. I believe there is fear in the community of mental health providers and other healthcare providers about the repercussions from the community.
BY MR. HILDABRAND:
Q. On the right column of this PDF page five, Journal page 246, do you see where it describes establishing affirmative schools? Healthcare professionals can work with educational personnel to establish affirmative schools. Do you see that?
A. Which page is that on? I'm sorry.
Q. PDF page five, 246 in the Journal pagination.

The right column, kind of upper right.
A. I don't think I'm seeing the sentence or statement that you are looking for. Can you say it again, please?
Q. Of course. Do you see: In the community in settings where youth interact frequently, healthcare professionals can work with educational personnel to establish affirmative schools and spaces that provide a safe place for TGD patients?
A. Yes. I have located that.
Q. Can you explain for me what an affirmative school is as you used that phrase here?
A. So we likely used the term "affirmative school" to represent schools that engage in affirmative practices that have been well established in support of transgender students.
Q. Are you an expert in educational practices?
MS. BROWN: Objection to form.
THE WITNESS: I am not an educator or an expert in educational practices.
BY MR. HILDABRAND:
Q. All right. So that's -- those are all the questions about that article. But before we leave this document, can you turn to PDF page six, Journal page 247.

What is the title of the article that followed the one that you co-authored?
A. It says: Advocacy Opportunities from Academics Community Partnership. Three Examples from Transcollaboration.
Q. Are articles about advocacy the sorts of articles that often appear in this sort of journal?
MR. HILDABRAND: Objection to form.
THE WITNESS: I believe this journal called The Behavior Therapist is a part of professional organizations of psychologists and mental health professionals and this particular journal had a call for submission related to supporting special patient population.
BY MR. HILDABRAND:
Q. So they specifically requested articles about supporting patient populations such as transgender children and adolescents?
A. I believe that's true. Yes.
Q. Okay. Let's go back to your expert report. This is Exhibit 1, Doc A. And we're going to go to footnote eight, which is on page five of the report.
A. Okay. We're there.
Q. Do you see where you cited an article by Rafferty, J.?

A. Yes.
Q. Insuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents; is that the title of the article it appears?
A. Yes.
MR. HILDABRAND: All right. Travis, can you circulate Document R. We'll mark this as Exhibit 11, I believe is the number we're on.
(WHEREUPON, a document was marked as Exhibit Number 11.)
BY MR. HILDABRAND:
Q. Dr. Cyperski, is this the article by Jason Rafferty that you cited in your expert report?
A. It appears so, yes.
Q. Now, was this article, I believe it has a date down at the bottom of the page of October 2018; is that correct?
A. Yes.
Q. So this is published less than four years ago from today; is that correct?
A. If the math is right, yes.
Q. Is this an article from the American Academy of Pediatrics? Is that what it says in the bottom right?

A. It does.
Q. Are you a pediatrician?
A. I am not.
Q. Is this the sort of article that you would rely upon, though, as a psychologist?
A. I'm not sure that I would rely on this article and it was cited in context of the report and we could consider it in that context.
Q. Fair enough. Let's turn to -- it's Table 1 but it's on page two of the PDF.
A. Table 1, yes, we're there.
Q. Do you see it says: Relevant terms and definitions related to gender care?
A. Uh-huh.
Q. What is the first term?
A. The first term is sex.
Q. Can you read the definition of sex in Table 1?
A. Sure. It says: An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels.
Q. Do you agree with this definition of sex or is there an alternative definition that you provide?

Just let me know if you would tweak it in any way or provide a different definition.

MS. BROWN: Objection to form.

THE WITNESS: This appears to be an acceptable definition.

BY MR. HILDABRAND:

Q. Does this table define the term "gender" by itself?

A. I am not seeing that.

Q. Can you look at the term at the definition of agender about halfway down through the table and can you read that definition for us?

A. Uh-huh. Agender: A term used to describe a person who does not identify as having a particular gender.

Q. All right. In your professional experience, would you agree that some people do not have a particular gender?

MS. BROWN: Object to form.

THE WITNESS: In my experience an individual may identify as agender.

BY MR. HILDABRAND:

Q. In your experience, would someone identify as not having a particular gender?

A. I have not heard someone use the terms of "I

don't have a particular gender". I have heard people use the gender identity label of agender.

Q. Do any of your patients use that label to describe themselves?

A. I do not believe so.

Q. Let's go down to page three, under where it says, Mental Health Implications.

A. Okay. We are there.

Q. Do you see where it says: Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder but this association is not yet well understood? Would you agree with that sentence, or are there any parts of that sentence that you disagree with?

MS. BROWN: Object to form.

THE WITNESS: If this is one statement within some broader context, I don't see a reason to object with this statement.

BY MR. HILDABRAND:

Q. All right. Do you see farther down in this column where it says: Some youth who identify as TGD also experience gender dysphoria. Are there some youth who identify as transgender or gender diverse who do not experience gender dysphoria?

A. Some individuals of transgender identity or a

gender diverse identity do not experience gender dysphoria.

Q. Would it be acceptable in the standards of care to provide puberty blockers to a transgender individual who does not experience gender dysphoria?

MS. BROWN: Objection to form.

THE WITNESS: My interpretation of the practice guidelines suggests that yes, it may be appropriate.

BY MR. HILDABRAND:

Q. Would it also be appropriate to provide hormone therapy to a transgender individual who does not have gender dysphoria?

MS. BROWN: Objection to form.

THE WITNESS: So the decision about whether to pursue hormone therapy would be made between the patient and their legal guardians and their treatment team and the guidelines would support and inform the treatment plan.

BY MR. HILDABRAND:

Q. So a treatment plan might include hormone therapy for a transgender individual who does not have gender dysphoria if in those individual circumstances the patient health provider and legal guardian or parent decide on that course of action?

MS. BROWN: Object to form.

THE WITNESS: So the treatment plan for gender incongruence and what would be specifically required by the individual in question, that would be decided upon -- the treatment plan, to be clear, would be decided upon in collaboration and through an evaluation of the patient in collaboration with their legal guardian, and with their treating provider.

BY MR. HILDABRAND:

Q. And so yes or no? It might include hormone therapy even if the individual does not have gender dysphoria?

MS. BROWN: Same objection.

THE WITNESS: Yes. The treatment plan may include hormones for an individual with gender incongruence.

BY MR. HILDABRAND:

Q. So you're using a different term here. For an individual who does not have gender dysphoria, yes or no, could you answer that question not using the term "gender incongruence"?

MS. BROWN: Same objection.

THE WITNESS: Can you repeat the question for me then?

BY MR. HILDABRAND:
Q. Yes. For a transgender individual who does not have gender dysphoria -- we can have the conversation about gender incongruence in a minute. But for a transgender individual who does not have gender dysphoria, might it be acceptable for that individual or might their treatment plan include hormones? Yes or no? And then provide any additional explanation you'd like.

MS. BROWN: Same objection.

THE WITNESS: Yes. A treatment plan for a transgender individual with or without gender dysphoria may include the use of gender-affirming hormones as, again, would be decided upon after careful and thoughtful evaluation, collaboration among all the parties we've discussed before -- the patient, particularly in adolescence, their legal guardian, and their treatment team.

BY MR. HILDABRAND:
Q. And might a treatment plan for a transgender individual who does not have gender dysphoria also include surgery? Yes or no? And then any further explanation.

MS. BROWN: Same objection.

THE WITNESS: We would look to the

guidelines to support decisions about treatment planning. But it is possible that an individual who identifies as transgender or gender diverse may not experience gender dysphoria and could decide or move forward with gender-affirming surgery.

BY MR. HILDABRAND:

Q. All right. So you mentioned the term "gender incongruence". What does that mean?

A. Uh-huh. So gender incongruence would be similar to what we've discussed before around gender identity, in which an individual's gender identity would be incongruent or does not match or is not aligned with the sex they were assigned at birth.

BY MR. HILDABRAND:

Q. Is that a mental health condition to be gender incongruent?

MS. BROWN: Objection to form.

THE WITNESS: It is not a mental health condition and is not considered to be pathological to have a transgender identity or experience gender incongruence.

MR. HILDABRAND: Thank you. All right. Travis, turn to page five in this document. It's page five in the PDF and that's also the page that is here. Make our life real easy. Go to where you

can see pubertal suppression.

MS. BROWN: Sorry. Give us one moment. The mouse went out.

MR. HILDABRAND: Of course, yes.

BY MR. HILDABRAND:

Q. Can you read the first sentence under pubertal suppression?

A. Just so I remember, this is the AAP publication; is that right?

Q. Yes. It's --

A. Okay.

Q. -- the American Academy of Pediatrics.

A. Okay. Thank you. Under pubertal suppression, it says: Gonadotrophin-releasing hormones have been used to delayed puberty since the 1980s for central precocious puberty.

Q. Thanks.

A. Do you want me to keep going?

Q. No, that's fine. Is that your understanding as well that these have been used since around the 1980s?

A. That would be a great question for an endocrinologist. However, that's my understanding.

Q. Would these gonadotrophin-releasing hormones, are these often referred to as puberty blockers or

puberty suppressors?
A. Yes.
Q. Are some of your patients on puberty blockers or puberty suppressors? And feel free to tell me which term you prefer to refer to them.
A. Sure. In my mental health practice, I do not believe I have patients that are currently on puberty-blocking medications. So there are patients in the VPATH Clinic who are on pubertal blockers.
MR. SANDERS: Clark, can I interrupt for a second?
MR. HILDABRAND: Yes.
MR. SANDERS: This is David Sanders, Madam Court Reporter. I'm going to log off at this point. Jessica Jernigan Johnson in my office has logged on. She's already counsel of record in the case so she's just in for me.
MR. HILDABRAND: Sounds good. Thanks, David.
MR. SANDERS: See you-all tomorrow.
MR. HILDABRAND: See you tomorrow.
BY MR. HILDABRAND:
Q. On the right-hand column --
A. Uh-huh.
Q. -- do you see about halfway down the page

where it says pubertal suppression is not without risk?
A. Yes.
Q. Do you agree with that statement or is that something that we should ask somebody else?
MS. BROWN: Objection to form.
THE WITNESS: Discussing the risks and benefits of pubertal suppression is within the specialty of endocrinology. So it may be a good question for them.
BY MR. HILDABRAND:
Q. That's fair. Thank you. So turning to page six in the PDF. When you get there, do you see a Table 2, the process of gender affirmation may include greater than or equal to one of the following components?
A. Yes, I do.
Q. Do you see that table?
A. Yes, I do.
Q. Thank you. And is the first component social affirmation?
A. That's what I'm seeing, yes.
Q. As a psychologist, is that something that you can understand that component and speak about as an expert?

A. Yes.
Q. The second one, is that puberty blockers?
A. Yes.
Q. Is that something that you can speak to as an expert?
MS. BROWN: Objection to form.
THE WITNESS: I would be curious about what speak to refers to and what questions you may ask specifically.
BY MR. HILDABRAND:
Q. Are you offering any expert testimony about puberty blockers?
MS. BROWN: Objection to form.
BY MR. HILDABRAND:
Q. Or do you have sufficient experience and knowledge to offer expert testimony about puberty blockers?
MS. BROWN: Objection to form.
THE WITNESS: I think it would depend on the particular questions and context related to pubertal blockers. We work within an Interdisciplinary Clinic so often I myself need to consult with the endocrinologist about some of these terms and practices.
/ /

BY MR. HILDABRAND:
Q. So you yourself don't prescribe the puberty blockers; is that correct?
A. That's correct.
Q. And so the next component listed cross-sex hormone therapy. And, again, you yourself do not prescribe cross-sex hormones; is that correct?
A. That's correct.
Q. Is the phrase "cross-sex hormone" or "cross-sex hormone therapy", are those phrases that you have heard in your practice, though?
A. I have heard those terms. We now prefer the term "gender-affirming hormones."
Q. About when in your practice did that preference change?
MS. BROWN: Object to form.
THE WITNESS: Uh-huh. I'm not sure of the specific time line. Again, the terminology and practices are updating all the time. But I would say within the past couple of years.
BY MR. HILDABRAND:
Q. Thank you. That's helpful. And then gender-affirming surgeries, you don't perform yourself gender-affirming surgeries; is that correct?

A. I do not.
Q. Are you aware of what gender-affirming surgeries might entail for your patients, though?
A. Yes.
Q. What sort of surgeries would you consider gender-affirming surgeries?
A. Uh-huh. The table provides a pretty good definition. So top surgery, which might include creating a male typical chest shape (inaudible) --
(Court Reporter interrupts for clarity.
THE WITNESS: I'm reading from the table. But top surgery, which would be to create a male-typical chest shape or enhanced breasts. Then there would be bottom surgery, which would be surgery on genitals or reproductive organs. And there may be surgeries such as facial feminization or other procedures, including various other procedures.
BY MR. HILDABRAND:
Q. For top surgery, you described creating a male-typical chest shape or enhanced breasts?
A. Uh-huh.
Q. For someone born with a sex assigned at birth of female, would that involve mastectomies?
A. Often I think this would be discussed between

an individual patient and their surgeon. But yes, often there is a -- my understanding is there is a double mastectomy and then re-creation of affirmative chest.

Q. And for bottom surgery, I think it's described as surgery on genitals or reproductive organs. For those natal boys or individuals born with the sex assigned at birth of male, would that involve removing their penis and using it to construct the vagina?

MS. BROWN: Object to form.

THE WITNESS: So for an individual assigned male at birth, there may be a variety of surgeries that they determine to be medically necessary for each individual. And just remind everyone that moving through gender-affirming surgery or receiving gender-affirming surgery and the treatment plans here are individualized to each patient. So not all patients seek surgery to begin with.

BY MR. HILDABRAND:

Q. But is that a surgery that some patients may receive?

A. Which surgery is that?

Q. The removing -- cutting off their penis and

using that to shape an artificial vagina, is that a bottom surgery that some natal boys may receive?

MS. BROWN: Object to form.

THE WITNESS: So I'm not sure as to the details of how the surgeries are performed. That would be a great question for a plastic surgeon. But some individuals who may seek bottom surgery may experience changes to their genitalia and creation of genitalia that would be more consistent with their gender identity.

BY MR. HILDABRAND:

Q. Have any of your patients received top surgery?

MS. BROWN: Objection to form.

THE WITNESS: I have had patients who have received top surgery, yes.

BY MR. HILDABRAND:

Q. What is the youngest age of a patient of yours who has received top surgery?

A. This is a bit of a complex question and nuanced about the way they practice. So I'm thinking about patients in my mental healthcare practice and I think the youngest I have worked with them in my mental healthcare practice would be 18, I believe.

Q. Eighteen at the time of the surgery; is that correct?
A. Yes. Many are older and college aged.
Q. And what is the youngest age you can recall for one of your patients receiving bottom surgery?
MS. BROWN: Objection to form.
THE WITNESS: I am not aware of that bottom surgery performed on individuals younger than 18.
BY MR. HILDABRAND:
Q. So the same age for top surgery?
MS. BROWN: Object to form.
THE WITNESS: Can you repeat the question for me?
BY MR. HILDABRAND:
Q. That's okay. We can -- we can move on. That's all right. All right.
On PDF page eight, can you go there?
A. Page eight. Give us a minute.
Q. And the quotation will extend from the bottom of page eight to page nine, if that's helpful for what you're pulling up.
A. Okay. I think we're there.
Q. Thanks. Do you see the sentence that says: Youth who identify as TGD are becoming more visible

because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities.

Do you agree with this statement? And let me know if there are any parts that you would disagree with.

A. I think I would need some more information about what the authors mean by admissible, a word I'm not understanding in the context, I don't think.

Q. So other than the increase in admissible, would you agree that youth who identified as TGD are becoming more visible in the media, on social media, and in schools and communities?

A. Yes, there is increased visibility of the transgender community, although it is still quite limited.

Q. All right. We're going to put this article to the side and go back to your expert report.

A. Okay.

Q. It's Exhibit 1. We are just going back to footnote eight here on page five.

A. Okay. We are there.

Q. Do you see where you cite the 2015 article from the American Psychological Association, Guidelines for Psychological Practice of Transgender

and Gender-Nonconforming People?

MR. HILDABRAND: Can y'all hear us? Let's go off the record for a second while they reestablish audio if that's all right.

(Recess observed.)

MR. HILDABRAND: Before we go back to questions, I have that we are at four hours and 57 minutes on the record. Is that what opposing counsel has as well?

MS. BROWN: That sounds accurate. We'll trust you.

MR. HILDABRAND: All right.

MS. BORELLI: Are you tracking, Ms. Honeycutt?

(Off-the-record discussion.)

MR. HILDABRAND: I hope we don't have to use down to the last minute but we'll see. All right.

BY MR. HILDABRAND:

Q. So going back, you saw where you cited the 2015 American Psychological Association article, correct?

A. In footnote eight. Yes, I'm with you.

MR. HILDABRAND: Great. Travis, can you circulate Doc M. And we'll mark this as Exhibit 12.

(WHEREUPON, a document was marked as Exhibit Number 12.)

BY MR. HILDABRAND:

Q. Does this appear to be the article that you cited in your expert report?

A. It does.

Q. Let's go to the second page in the PDF, Journal page 833.

A. Okay.

Q. Do you see at the first full paragraph where it says: Given the added complexity of working with TGNC and gender-questioning youth and the limitations of available research, the guidelines focus primarily, though not exclusively, on TGNC adults? Is that what the article says?

A. I see that text, yes.

Q. Do you agree that there is added complexity with working with transgender and gender-questioning youth?

MS. BROWN: Object to form.

THE WITNESS: The mental health field in general, I believe that there is added complexity working with children and adolescents of all gender identity. That includes cisgender children and adolescents.

BY MR. HILDABRAND:
Q. And are there any limitations to the available research regarding transgender and gender-questioning youth?
MS. BROWN: Objection to form.
THE WITNESS: There are limitations in every field of research and particular to each article they may have their own limitations.
BY MR. HILDABRAND:
Q. Are there any limitations particular to research regarding transgender and gender-questioning youth?
MS. BROWN: Same objection.
THE WITNESS: Particular in what way?
BY MR. HILDABRAND:
Q. So you mention that all fields can have limitations. Are there any limitations that you can think of specifically for research regarding transgender and gender-questioning youth?
MS. BROWN: Same objection.
THE WITNESS: No.
BY MR. HILDABRAND:
Q. So these are just limitations that any field of research would have?
MS. BROWN: Objection to form.

THE WITNESS: There may be limitations present in all fields of study, and I cannot think of unique limitations in this field of study.

BY MR. HILDABRAND:

Q. Do you use these guidelines in this article during your practice as a psychologist?

MS. BROWN: Objection to form.

THE WITNESS: I have reviewed these guidelines. We primarily rely on the Endocrine Society and the WPATH.

BY MR. HILDABRAND:

Q. So these guidelines are -- you might consider these guidelines, but these are not guidelines that you would rely upon as much as the WPATH Standards of Care or the Endocrine Guidelines; is that correct?

MS. BROWN: Objection to form.

THE WITNESS: These are guidelines I have reviewed and considered. And the standards of care from the WPATH and the Endocrine Society Guidelines are the primary sources in our field.

BY MR. HILDABRAND:

Q. Thank you. Do these guidelines in this article focus primarily on adults?

MS. BROWN: Objection to form.

THE WITNESS: I would need to re-review this particular article.

BY MR. HILDABRAND:

Q. So you're not aware off the top of your head if this article focuses primarily on adults?

MS. BROWN: Same objection.

THE WITNESS: Off of the top of my head, I recall this article references both youth and adults.

BY MR. HILDABRAND:

Q. That's fair. On the right-hand side, do you see where it says distinction between standards and guidelines?

A. I do.

Q. Can you read the sentence under that heading?

A. Sure. So it says: When using these guidelines, psychologists should be aware that APA has made an important distinction between standards and guidelines. Should I keep going?

Q. Yes. If you want to keep going for the next sentence.

A. All right. The standards are mandates to which all psychologists must adhere, e.g., the ethical principles, a psychologist, and code of conduct, whereas guidelines are aspirational.

Q. Do you agree that guidelines are aspirational?

MS. BROWN: Objection to form.

THE WITNESS: I think guidelines are guidelines that can inform in a very important way treatment plans and best practice.

BY MR. HILDABRAND:

Q. Do you view there as being a distinction between guidelines and standards of care?

MS. BROWN: Same objection.

THE WITNESS: In this context, as referenced in this article, I understand the distinction that they're making between standards and guidelines.

BY MR. HILDABRAND:

Q. Is that a distinction you make in your practice as a psychologist?

MS. BROWN: Objection to form.

THE WITNESS: I am not sure I have really thought in depth about the definition between standards and guidelines.

BY MR. HILDABRAND:

Q. All right. Now let's look at page three in the PDF. Do you see it says foundational knowledge and awareness?

A. Yes.
Q. And it says: Guideline one: Psychologists understand that is gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth?
A. Yes. Uh-huh.
Q. Do you agree with the statements in that guideline or are there any that you disagree with?
A. I can agree with that statement.
Q. For the first sentence that says rationale, can you read the first sentence there?
A. Yes. It says: Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female, a boy, a man, or male, a blend of male or female, or an alternative gender.
Q. Do you agree with that statement or are there any components of it that you disagree with?
A. So this is one particular statement in what I believe is an older document, if I remember correctly, and is in process of being updated. I think it could be stated better and more precisely in a future iteration.
Q. And this was published, I think at the bottom it says December 2015; is that what it says?

A. Yes.
Q. It's already outdated less than seven years later; is that correct?
MS. BROWN: Object to form.
THE WITNESS: So seven years can be a long time in scientific literature. There may be many advances in that time. It's likely that when these guidelines and papers such as these are developed that they are in the works for many years and in committee for many years prior to their publication date.
BY MR. HILDABRAND:
Q. Do you agree that gender identity can be a blend of male or female?
A. Yes, I think gender identity could be a blend.
Q. All right. Let's go forward to page 11 in the PDF. This is Journal page 842. Do you see the paragraph that begins: A clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature?
A. Yes, I see that paragraph.
Q. Can you read the next sentence there?
A. Sure. I'm going to read the first sentence again just so I'm in the right place. Sorry. A

clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood and because no approach to working with TGNC children has been adequately empirically validated consensus does not exist regarding best practice with prepubertal children.

Q. Do you agree that reasonable psychologists can differ about the proper treatment of transgender youth?

MS. BROWN: Objection to form.

THE WITNESS: And what do you mean by a reasonable psychologist?

BY MR. HILDABRAND:

Q. You tell me. Is that something that a psychologist who you could respect could disagree with how you approach treating a transgender child?

MS. BROWN: Same objection.

THE WITNESS: Professionals do sometimes differ in their approach to treatment plans or treatment strategies for children and all kinds of conditions.

BY MR. HILDABRAND:

Q. Let's go to the next paragraph. Do you see

where it says: One approach encouragings an affirmation and acceptance of children's expressed gender identity?
A. Yes, I see that paragraph.
Q. In your practice, is that more -- is that similar to the approach that you try to take of affirming the child's expressed gender identity?
MS. BROWN: Objection to form.
THE WITNESS: In my practice, I work closely and intentionally with each patient and their caregiver to assess their gender identity and to collaborate on an appropriate treatment plan.
BY MR. HILDABRAND:
Q. And so then the next paragraph begins: In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. Is that what the article says?
A. I think in that paragraph I'm going to repeat it back just to be sure. In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. That's what this text states.
Q. Is that second approach consistent with your practice?

MS. BROWN: Objection to form.

THE WITNESS: The approach that's described in this statement I would need more information around. At first blush, it sounds like a practice that is no longer supported in the literature.

BY MR. HILDABRAND:

Q. So then the next sentence says: This includes endorsing and supporting behavior and attitudes that align with the child's sex assigned at birth prior to the onset of puberty. Is that an approach that psychologists no longer take?

MS. BROWN: Objection to form.

THE WITNESS: So the statement -- this includes endorsing and supporting behaviors and attitudes that align with the child's sex assigned at birth prior to onset of puberty. I think it would be important to assess each individual child and their needs. However, encouraging a transgender child or gender incongruence to identify and behave as their sex assigned at birth could be consistent with something called conversion therapy.

Q. So do you view this second approach as conversion therapy?

MS. BROWN: Objection to form.

THE WITNESS: I would need more information about what the authors were intending and maybe to read some additional context.

BY MR. HILDABRAND:

Q. Feel free to read the rest of the paragraph if you want to but --

A. Sure.

Q. Do you want to do that? Then I'll return to the question in a second?

A. Okay. That would be great. Thank you so much. Okay. I finished reading that paragraph.

Q. Is conversion therapy -- before we get back to this, is conversion therapy an acceptable or unacceptable choice of therapy for a psychologist?

MS. BROWN: Objection to form.

THE WITNESS: Conversion therapy is unacceptable and unethical. It's been found to be harmful to patients.

BY MR. HILDABRAND:

Q. Based on what this second approach is described as here, would you view this as conversion therapy?

MS. BROWN: Objection to form.

THE WITNESS: Again, I would need some more information. But it sounds consistent with

conversion therapy and I appreciate the context later in the paragraph, that when addressing psychological interventions for children and adolescents, the WPATH standards of care identify interventions "aimed at trying to change gender identity and expression to become more congruent with the sex assigned at birth as unethical, with hopes that future research will offer improved guidance in this area of practice".

BY MR. HILDABRAND:

Q. So based on what you see here, you would agree with WPATH that this second approach would be unethical?

MS. BROWN: Objection to form.

THE WITNESS: I would agree that conversion therapy is unethical. And indeed the American Psychological Association has also posted statements in support of this belief as well since the time that these guidelines came out.

BY MR. HILDABRAND:

Q. You mentioned at the time these guidelines came out. Has this approach ever been viewed as more acceptable amongst psychologists?

MS. BROWN: Objection to form.

THE WITNESS: Many years ago people were

practicing conversion therapy but it's very important to note that this has been widely identified and clearly articulated by mental and medical health professionals and inappropriate, unethical, and harmful --

BY MR. HILDABRAND:

Q. Just to be --

A. -- and no longer practiced.

Q. Just to be clear about many years, is that ten years ago or longer?

A. I don't know the specifics of folks who practice conversion therapy or have practiced conversion therapy in the past.

Q. All right. So in the upper right column, do you see where it says consensus does not exist regarding whether this approach may provide benefits or may cause harm or lead to psychosocial adversities?

A. I see that statement listed here.

Q. Do you think that there is now consensus?

A. I do believe that is there is consensus now that conversion therapy is harmful.

Q. Farther down the right column on page 11, do you see -- it's about halfway down in the first full paragraph?

A. Uh-huh.
Q. Do you see where it says: Complicating their clinical presentation, many gender-questioning adolescents also present with co-occurring psychological concerns, such as suicidal ideation, self-injurious behaviors, drug and alcohol use, and autism spectrum disorders? Is that what the article says with additional in-line citations?
A. I see that in the article, yes.
Q. Do you agree with that statement? Are there any components of it that you disagree with?
A. There are many possible co-occurring conditions and it's very common in child adolescent mental health broadly for there to be co-occurring diagnoses or conditions.
Q. Do you see where it says: Additionally, adolescents can become intensely focused on their immediate desires?
A. I see that, yes.
Q. Is that something you observed about adolescents in your practice?
MS. BROWN: Objection to form.
THE WITNESS: So questions about adolescents who may become intensely focused on immediate desires, I believe this is regarded as an

experience of adolescence, where they may be focused on what brings them pleasure or are unable to delay gratification for some individuals.

BY MR. HILDABRAND:

Q. Now I want to move forward to page 29 in the PDF. It's page 860 in the Journal. Do you see where its says Appendix A definitions?

A. Yes, I see Appendix A.

Q. Do you see the sentence: Terminology within the healthcare field in transgender and gender non-conforming TGNC communities is constantly evolving?

A. Yes.

Q. Do you agree that this terminology is constantly evolving?

A. I agree it is often evolving. Constantly is a very specific frequency.

Q. Thanks for clarifying.

A. Sorry.

Q. The second sentence says: The evolution of terminology has been especially rapid in the last decade as the profession's awareness of gender diversity has increased as more literature and research in this area has been published and as voices of the TGNC community have strengthened? Do

you agree with this statement?
A. I think there has been increased proliferation of research and awareness of gender diversity in the past decade, yes.
Q. Given the change that's occurred in the past decade, as a psychologist, do you think that the field of psychology should slow down a little bit or take a more conservative approach to this change in terminology?
MS. BROWN: Objection to form.
THE WITNESS: In best practices in the mental health field, it has been well established that using terminology consistent with our patients' understanding of their culture and their identity is important to delivering culturally competent care. And in the fact that terminology may be changing and evolving, it would be important to remain updated on that terminology and to continue to meet our patients where they're at, again, as consistent with culturally competent care.
BY MR. HILDABRAND:
Q. So now I'm going to ask to scroll through the definitions, specifically, since they go in alphabetical order, pages 30 and 31, in the PDF pages 861, 862 in the document. And let me know if

you see a definition of the word "gender" standing by itself?
A. We are scrolling. I did not see a definition on page 861. We've made it to the alphabetical section of H and did not see a specific definition for the term "gender".
Q. Thank you. On page 862, do you see a definition of sex?
A. I see sex or sex assigned at birth.
Q. And is the first sentence there: Sex is typically assigned at birth or before during ultrasound based on the appearance of external genitalia?
A. Yes, I see that.
Q. And feel free to read the additional context they provide there in that definition. But once you've done so, can you let me know if you agree with the definition here or if they're related how you would change it?
A. I've read the definition. I think the current definition of sex and how sex is assigned, including the many factors of informed sex, like internal genitalia, chromosomal and hormonal sex, that those would be considered for all individuals and not just when external genitalia are ambiguous.

MR. HILDABRAND: Thank you for clarifying. I believe we have entered this already as Exhibit 12; is that correct?

COURT REPORTER: Yes, sir.

MR. HILDABRAND: Great. Thank you. I just wanted to make sure before we moved on. All right.

BY MR. HILDABRAND:

Q. Let's go back to Exhibit 1, your expert report.

A. Okay.

Q. And we're still on for there page five, but now we are going to turn to footnote nine.

A. I see footnote nine.

Q. Do you cite a state advocacy update there?

A. From the American Medical Association, yes.

MR. HILDABRAND: Travis, can you circulate Doc N. And we will mark this as Exhibit 13.

(WHEREUPON, a document was marked as Exhibit Number 13.)

BY MR. HILDABRAND:

Q. Dr. Cyperski, does this appear to be the March 26, 2021, state advocacy update from the AMA that you've cited?

A. Yes.
Q. Are state advocacy updates the source or sources that psychologists usually rely on in forming their opinions?
MS. BROWN: Object to form.
THE WITNESS: This document deals within the scope of the opinions that I provided.
BY MR. HILDABRAND:
Q. So would it be the sort -- so is it a document you relied upon in forming your expert opinion?
A. Yes.
Q. So you see where it says, AMA fights to protect healthcare for transgender patients?
A. Yes.
Q. Is it normal for medical associations to fight political battles?
MS. BROWN: Object to form.
THE WITNESS: Normally the specific term, it is very common for professional organizations to make policy statements or updates such as this.
BY MR. HILDABRAND:
Q. Then in the last -- do you see the sentence, before criminalizing healthcare for transgender

minors that says: The AMA state advocacy resource center remains actively engaged in defeating legislation that would harm transgender patients?
A. Yes, I see that statement.
Q. Are you aware that the AMA has an advocacy resource center?
A. I am not familiar with the AMA organizational structure but it is listed in this document that they have an advocacy resource center.
Q. Is it customary for the AMA to actively attempt to defeat legislation?
MS. BROWN: Objection to form.
THE WITNESS: Again, I'm not familiar with the particulars of the AMA and their activities within the organization. I think it makes sense that physicians and professionals would work to protect their patients and to defeat things including legislation that would harm their patients.
BY MR. HILDABRAND:
Q. Do you see farther down where it says: The AMA used these bills as a dangerous legislative intrusion into the practice of medicine and has been working closely with state medical associations to vigorously oppose them.

A. I see that statement, yes.
Q. Is it dangerous for state legislatures to intrude into the practice of medicine?
MS. BROWN: Objection to form.
THE WITNESS: I think it would be important to define the word "dangerous".
BY MR. HILDABRAND:
Q. So you cited this article to support your expert report. How do you understand the word "dangerous" as it is used here?
A. Uh-huh. So defining in context, might be AMA used these bills as a harmful endeavor and dangerous legislative intrusion into the practice of medicine and working closely with state medical associations to vigorously oppose them.
Q. So is some legislative intrusion into the practice of medicine acceptable?
MS. BROWN: Object to form.
BY MR. HILDABRAND:
Q. Or not dangerous?
MS. BROWN: Same objection.
THE WITNESS: It's my experience that the practice of medicine should be guided by best practice guidelines and by the current state of the literature and the science that guides their

practice.
BY MR. HILDABRAND:
Q. Not guided by the decisions of elected officials?
MS. BROWN: Objection to form.
THE WITNESS: I am not aware of the fact that elected officials are trained medical professionals, although some of them may be. And to the extent to which they are current and up to date in the scientific literature about the practices of medicine.
BY MR. HILDABRAND:
Q. So is it your position that only medical professionals should decide how to limit the practice of medicine?
MS. BROWN: Objection to form.
THE WITNESS: I believe the practice of medicine should be informed by the current state of the science, as well as by the patients that are served by the medicine and populations of individuals who are impacted by them and by many other factors as well.
BY MR. HILDABRAND:
Q. So to give a yes or no, is it -- to yes or no, should the practice of medicine only be

restricted by medical professionals? And then feel free to explain.

MS. BROWN: Same objection.

THE WITNESS: It's very difficult to answer any question when posed with an always or an only or an absolute, and we often must consider the complexities, particularly when it comes to the health and wellbeing of people.

BY MR. HILDABRAND:

Q. All right. Now let's turn to page two of the PDF. Do you see under where it says, excluding transgender youth from athletics, where it says: Another concerning trend are bills that would prohibit transgender women and girls from participating in school athletics consistent with their gender identity?

A. I see the statement, yes.

Q. So do you understand the AMA to take the position that these bills are a concerning trend?

A. Yes, that's my understanding.

Q. Are you concerned that the AMA is taking a position on a political question?

MR. HILDABRAND: Objection to form.

THE WITNESS: Can you restate that, or repeat the question for me, please?

BY MR. HILDABRAND:
Q. Yes. Is it a concern for you as a psychologist that the AMA is picking sides in political debates?
MS. BROWN: Same objection.
THE WITNESS: I'm not sure they are picking sides in political debates and instead are offering an opinion about what would promote health and wellbeing and resiliency in a particular patient population that they serve.
BY MR. HILDABRAND:
Q. All right. Move down to where it says: In 2020, Idaho became the first-ever state to enact a ban on transgender minors' participation in youth athletics. The law was challenged and blocked by a federal court in August 2020. The AMA, along with the American Academy of Pediatrics and other healthcare organizations, submitted a Friend of the Court brief with the Ninth Circuit Court of Appeals noting that the law undermines the accepted approach for treating gender dysphoria.
So is it your understanding that the AMA and the American Academy of Pediatrics have taken a side against the Idaho legislation?
A. Based on what's written in this document, it

appears as though the AMA and the AAP and other healthcare organizations submitted a brief noting that the law undermines the accepted approach for treating gender dysphoria.

Q. So do you view the AMA as an impartial source of information on the appropriateness of the law challenged in this case?

MS. BROWN: Objection to form.

THE WITNESS: I believe the AMA is taking a stance about what promotes wellbeing and resiliency in patients that they treat, including individuals with gender dysphoria, and seeking to promote health and wellbeing for individuals with gender dysphoria.

BY MR. HILDABRAND:

Q. So yes or no? Do you view them as impartial on the Tennessee law challenged in this case? And feel free to explain more.

MS. BROWN: Same objection.

THE WITNESS: I'm not sure how to answer that question. I'm so sorry.

BY MR. HILDABRAND:

Q. If you're not sure that's fine. We'll move on from that. Let's go back to your report, page five, again, footnote nine.

A. Okay. Footnote nine.
Q. And then do you see the last citation on that page to an AACAP 2019 article?
A. Yes.
MR. HILDABRAND: Travis, can you circulate Doc O. Dr. Cyperski, we'll mark this as Exhibit 14.
THE WITNESS: I have it open.
(WHEREUPON, a document was marked as Exhibit Number 14.)
BY MR. HILDABRAND:
Q. Dr. Cyperski, does this appear to be the AACAP statement that you cited in your expert report?
A. Yes.
Q. Looking down at the third paragraph, do you see the second sentence that reads: Blocking access to timely care has been shown to increase youths' risk for suicidal ideation and other negative mental health outcomes?
A. I'm not seeing that yet.
MS. BROWN: There's a lag in my scrolling. So if you can repeat it again.
BY MR. HILDABRAND:
Q. No problem.

A. What statement are we looking for?
Q. Sorry. The sentence is: AACAP strongly opposes any efforts, legal, legislative, and otherwise, to block access to these recognized interventions.
A. I see that statement.
Q. So is the AACAP taking a side in debate about legislation regarding transgender children and adolescents?

MS. BROWN: Objection to form.

THE WITNESS: I am not sure AACAP is taking a side so much as they are making a statement that the types of legal and legislative acts are incongruent with the current evidence-based clinical care that is important to those promoting the health and wellbeing of children and adolescents.

BY MR. HILDABRAND:

Q. So is the AACAP discouraging the passage of this sort of legislation?

MS. BROWN: Same objection.

THE WITNESS: Their statement states: AACAP opposed any efforts, legal, legislative, and otherwise, to block access to these recognized interventions.

/ /

BY MR. HILDABRAND:
Q. So do you view AACAP as an impartial organization when it comes to a law like the one challenged in this case?
MS. BROWN: Objection to form.
THE WITNESS: I am not familiar enough with AACAP and their organization in particular to determine if they are impartial or not.
BY MR. HILDABRAND:
Q. Going back down to the first paragraph, do you see the second sentence in that paragraph that says: Health promotion for all youth encourages open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines? Do you agree with this statement about what health promotion involves?
A. Health promotion involves many various components of lots of different practices, one of which would be exploration of all aspects of identity.
BY MR. HILDABRAND:
Q. Thank you. Let's put this to the side and go back to your expert report. And we'll stay with your expert report for a little bit longer this

time.
A. Okay.
Q. So look at paragraph 19, also on page five.
A. Paragraph 19, I see that.
Q. So you mention the widely accepted guidelines. Are those the Endocrine Society Guidelines and the WPATH Standards of Care?
A. Yes.
Q. Let's turn now to paragraph 20, which is on page six. Can you read the first sentence there for me?
A. Sure. The treatment for gender dysphoria is to reduce or eliminate the individual's clinically significant distress or impairments in functioning, which includes helping the patient to live in accordance with their gender identity.
Q. Is this the goal of treatment for gender dysphoria?
A. Yes, though there may be others well.
Q. Is a goal for treatment of gender dysphoria to help the child or adolescent become comfortable in the body he or she was born with?
MS. BROWN: Object to the form.
THE WITNESS: A goal of treatment for individuals with gender dysphoria would be to reduce

the distress or impairments that they feel and to help them live in accordance with their gender identity. That would be to decrease discomfort.

BY MR. HILDABRAND:

Q. But not to make them comfortable with their sex assigned at birth; is that correct? Is it to make them comfortable with their gender identity rather than their sex assigned at birth; is that correct?

MS. BROWN: Same objection.

THE WITNESS: I think this is a complicated and nuanced issue that's hard to answer distinctly and specifically and that the individual treatment plan for a particular patient would identify treatment goals for that individual.

BY MR. HILDABRAND:

Q. When you are creating patient treatment plans, is it more important when you're creating those for the individual to be comfortable with their gender identity or to be comfortable with their sex assigned at birth?

MS. BROWN: Objection to form.

THE WITNESS: Treatment plans often are aimed at reducing distress and impairment and improving positive psychology and functioning that

is often going to focus on supporting their gender identity and helping them seek congruence in their gender identity.

BY MR. HILDABRAND:

Q. For some patients, would it be more helpful -- I understand that is how several patients might be helped. But for some patients is it more helpful to encourage them to be comfortable in their sex assigned at birth rather than their gender identity?

MS. BROWN: Objection to form.

THE WITNESS: I would need more information about what you mean and what that treatment would look like. Again, in the description it sounds like the unethical practice of conversion therapy.

BY MR. HILDABRAND:

Q. So going down -- so in the second sentence here, you used the phrase "gender-affirming care". Is that a commonly used phrased among psychologists?

A. Among psychologists in the field, yes.

Q. And the same for gender transition?

A. We in the field tend to use gender-affirming care. Other terms like gender transition or transition-related care may also fall in this realm.

Q. Would other care providers understand what you mean when you use those terms?

MS. BROWN: Objection to form.

BY MR. HILDABRAND:

Q. Or do you understand what other healthcare providers mean when they use those terms?

MS. BROWN: Objection to form.

THE WITNESS: I believe there is consensus around gender-affirming care and would understand what an individual was referring to, though there's always room for further discussion and collaboration with the provider about the specific treatment that they're referencing.

BY MR. HILDABRAND:

Q. Moving down to paragraph 22. You say that -- we are talking about prepubertal children here. And the second sentence says: For these patients, social transition, living in accordance with one's gender identity may be appropriate. Is that what you said here?

A. Yes.

Q. And do you agree with that statement today?

A. That's correct.

Q. Might it also not be appropriate for some prepubertal children who have gender dysphoria for

them to socially transition?

MS. BROWN: Objection to form.

THE WITNESS: So can you repeat the question for me?

BY MR. HILDABRAND:

Q. Yes. So here it says: Social transition for prepubertal children may be appropriate. Is it always appropriate or are there scenarios where social transitions to prepubertal children with gender dysphoria is not appropriate?

MS. BROWN: Same objection.

THE WITNESS: I think there's two distinctions here that are important. There's the definition and practice of a social transition and then there is gender dysphoria. And those two are related and may inform one another but speak to the complexities of developing a treatment plan and when it may be appropriate to engage in which practice.

Q. So you say may be appropriate. So it may not be appropriate in some treatment plans for prepubertal children with gender dysphoria to socially transition; is that correct?

A. For prepubertal children with gender dysphoria specifically as a clinical diagnosis, it's likely that a social transition is appropriate for

the majority of those patients.
BY MR. HILDABRAND:
Q. So for the majority of those patients, are there some patients, even if they're minority, whom social transition would not be an appropriate treatment for gender dysphoria?
A. There are individual considerations for every child and family. And in the majority of cases, if a child has gender dysphoria, a social transition is an important part of their treatment plan that would promote health and wellbeing and resiliency.
Q. So percentage-wise when you say the majority, you mean greater than 50 percent but less than 100 percent; is that correct?
A. In which patient population are we talking about?
Q. So for prepubertal children with gender dysphoria, you say it may be appropriate in some situations. And then we discussed a little further and you said a majority of prepubertal children with gender dysphoria this would be appropriate. And I'm sorry to talk quickly there.
But when you use the word majority, do you mean greater than 50 percent but less than 100 percent?

A. In my personal practice, the individuals that I have met that have a diagnosis of gender dysphoria, it is often appropriate for them to initiate a social transition and they have initiated a social transition prior to arriving at my practice.
Q. But give me the yes or no format and then feel free to explain. Is it always appropriate for a prepubertal child with gender dysphoria to socially transition? Please give a yes or no and then you can continue if you need to.
A. I really can't give a yes or no because using terms like always, which are very complicated, always, no. There are individual nuances and circumstances that must be considered with every patient. For the majority of individuals, a social transition is appropriate.
Q. Thank you. So then I think it goes on to say that: After an individual begins puberty, medical intervention may be indicated, including puberty delaying medications and/or hormone therapy to initiate puberty consistent with one's gender identity. Individuals who receive hormone therapy develop secondary sex characteristics consistent with their gender identity.

What are sex characteristics consistent with their gender identity? And if you need to give an example, feel free to give examples for children based on what their sex assigned at birth would be.

MS. BROWN: Objection to form.

THE WITNESS: I'm happy to provide examples from my understanding and then some of the specifics may be more appropriate for a medical provider, an endocrinologist, or a primary care physician to address.

But, for example, a child who was assigned male at birth and identifies as a female and begins estrogen, for example, as an adolescent, they may start to develop some breasts and develop their chest that would be consistent with their gender identity.

For individuals who are assigned female at birth and have a transgender identity or identify as male and in adolescence initiate a course of testosterone treatments, they may develop characteristics consistent with clitoral enlargement, or facial hair, more body hair, things like that.

BY MR. HILDABRAND:

Q. Thank you. Let's turn now to paragraph 24.

This is on page seven of your report.
A. Okay.
Q. And there you mention typically male names, correct?
A. I see in the second sentence that there are transgender boys who have typically male names. Is that what you're referring to?
Q. Yes.
A. Okay.
Q. In your experience, do parents usually put a lot of effort into choosing a child's name?
MS. BROWN: Objection to form.
THE WITNESS: Some parents may put effort into choosing a name.
BY MR. HILDABRAND:
Q. And do some childrens' names carry deep significance to a family?
MS. BROWN: Objection to form.
THE WITNESS: Do some parents use family names for childrens' first names?
MS. BROWN: Same objection. And objection as to relevance.
THE WITNESS: Some parents use meaningful names or family names when assigning a name to their child.

BY MR. HILDABRAND:
Q. What if a child expresses a transgender identity and wishes to change a family name that their parents gave them; what should a parent do if the parent does not want to refer to their transgender child by a new name?
MS. BROWN: Objection to form.
THE WITNESS: In that hypothetical situation, it would be really important for the individual and their family to collaborate with a mental health provider. The research is very clear that using an individual's chosen name and pronoun is important and promotes their wellbeing in the short and long term.
BY MR. HILDABRAND:
Q. Is it always harmful to use a transgender child's pronouns that match their sex assigned at birth rather than their preferred pronouns?
MS. BROWN: Objection to form.
THE WITNESS: Typically it is harmful for an individual who has declared their gender identity and their pronouns to continue to be referred to by the pronouns of their sex assigned at birth.
/ /

BY MR. HILDABRAND:

Q. Was it harmful for parents to use pronouns consistent with the child's sex assigned at birth a year or two before the child expressed a transgender identity?

MR. HILDABRAND: Objection to form.

THE WITNESS: Is the question about whether it is appropriate for an individual to use pronouns consistent with sex assigned at birth when an individual has a cisgender identity consistent with their sex assigned at birth?

BY MR. HILDABRAND:

Q. So my question would be, so say you have a 12-year-old who tells the parents that the child is -- and we'll assume for this example that the child was assigned a sex of female at birth and the child tells the parents that the child is really a boy.

At that point on, you would advise the parents to use the male pronouns to refer to the child if that's what the child prefers, correct?

MS. BROWN: Objection to form.

THE WITNESS: It is important to use an individual's pronouns.

/ /

BY MR. HILDABRAND:
Q. So it would be harmful to then call the transgender boy by female pronouns; is that correct?
MS. BROWN: Same objection.
THE WITNESS: It is often harmful to use incorrect pronouns or misgender an individual.
BY MR. HILDABRAND:
Q. Was it harmful two years before the child expressed that the child was a transgender boy in that example?
MS. BROWN: Same objection.
THE WITNESS: I'm not sure I understand. So is it harmful when the child has a cisgender identity?
BY MR. HILDABRAND:
Q. So would you agree in that hypothetical that the child has a cisgender identity before expressing a transgender identity?
A. You'd have to repeat all of the specifics for me, I'm really sorry, in the hypothetical situation. But when an individual identifies as cisgender, it would be appropriate to use pronouns consistent with their cisgender identity. When an individual identifies as transgender, made a declaration about their pronouns, it is appropriate and supportive of

their mental health to use those pronouns. Does that -- sorry.

Q. I know it's hypothetical. Thank you for answering it as best you could.

MR. HILDABRAND: I think this is a good point for a break, if y'all would like to take a short break.

MS. BROWN: Ms. Honeycutt, during the break could you give us a time check if you have time and can add up what you've been recording on the record? I would really appreciate it. And, yes, we would like to take a ten-minute break. Thanks, Clark.

MR. HILDABRAND: Thanks.

(Recess observed.)

BY MR. HILDABRAND:

Q. Let's go back onto the record then. So in paragraph 24, do you see where it says: For some transgender adolescents, particularly those who have changed schools after initiating medical transition, their peers may not be aware that they are transgender; is that correct?

A. Yes.

Q. So this concern is particularly troubling for those who have changed schools after initiating

medical transition?

MS. BROWN: Objection to form.

THE WITNESS: I'm not sure what concern you're speaking of.

BY MR. HILDABRAND:

Q. The concern expressed in paragraph 24 of your report.

A. I'm going to need to review for context to be clear in what concern we are talking about.

Q. That's fine. We can move on then. Is it psychologically harmful to have separate teams for boys and girls?

MS. BROWN: Objection to form.

THE WITNESS: What would be meant by psychological harm?

BY MR. HILDABRAND:

Q. I believe you used the term "harm" in your report. So as you understand in your report, would it be harmful to have separate teams for boys and girls?

MS. BROWN: Same objection.

THE WITNESS: It is not necessarily harmful to have separate teams for girls and boys.

BY MR. HILDABRAND:

Q. Should teams be separated on the basis of

gender identity or on the basis of sex in your opinion as a psychologist?

MS. BROWN: Objection to form.

THE WITNESS: I am not an expert in designing team structure. I think the question is whether an individual should participate on a team based on their gender identity.

BY MR. HILDABRAND:

Q. Which team should nonbinary students play on if their gender identity is neither male or female?

MS. BROWN: Objection to form.

THE WITNESS: It would be important to collaborate closely with the nonbinary individual to determine a course of action and plan that was most appropriate to them in promoting their wellbeing.

BY MR. HILDABRAND:

Q. So we would ask the nonbinary individual which team they would prefer to play on?

MS. BROWN: Objection to form.

THE WITNESS: We would collaborate with the nonbinary individual to determine which team was appropriate for them.

BY MR. HILDABRAND:

Q. Should transgender students participating in athletic activities dress according to their sex or

according to their gender identity?

MS. BROWN: Objection to form.

THE WITNESS: It would be important for many transgender individuals to dress and participate in a manner consistent with their gender identity.

BY MR. HILDABRAND:

Q. So if a transgender boy found it important to the transgender boy's gender identity to dress like a boy, should that transgender boy dress like a boy while playing on boys' teams?

MS. BROWN: Objection to form.

THE WITNESS: It would be important for a transgender male who has engaged in a social transition to dress and appear in a manner consistent with the gender identity, in this case male.

BY MR. HILDABRAND:

Q. So if you had a 16-year-old transgender boy who found it important to dress like a boy, who was on a boys' swim team, should the transgender boy wear a swimsuit -- a boy's swimsuit?

MS. BROWN: Objection to form.

THE WITNESS: In that hypothetical scenario, I think it would be important to

collaborate with the individual about the uniform and dress that would be comfortable and safe for them to participate.

BY MR. HILDABRAND:

Q. If the individual insisted that -- if the transgender boy insisted that the transgender boy wanted to wear a boy's swimsuit, is that the correct swimsuit for the boy to wear?

MR. HILDABRAND: Objection to form.

THE WITNESS: In my clinical experience, I have not encountered that hypothetical scenario in which an individual would only want to wear a male swimsuit. It would be up to that individual to determine what was appropriate for them.

BY MR. HILDABRAND:

Q. So we discussed earlier how most transgender adolescents have not gone through surgery before they turn 18; is that correct?

A. Correct.

Q. Would it psychologically harm a cisgender girl to have to change in front of a transgender boy who still has a penis?

MS. BROWN: Objection to form. Irrelevant.

THE WITNESS: The question is about a

cisgender girl and locker room policies; is that right? Can you repeat the question?

BY MR. HILDABRAND:

Q. Yes. Would it harm a cisgender girl to have to change in front of a transgender girl who still has a penis?

MS. BROWN: Same objection.

THE WITNESS: I think it would be important to explore the risks and benefits. And the important issue is around the individual with their gender identity being permitted to participate in activities in the full scope that's consistent with their gender identity, and that would mean developing an individualized plan for what that would involve for that individual.

BY MR. HILDABRAND:

Q. So you cannot categorically say that it is inappropriate for a transgender girl who still has a penis to change in front of a cisgender girl; is that correct?

MS. BROWN: Same objection.

BY MR. HILDABRAND:

Q. Yes or no, and then please answer further if you need.

A. No. I think many cisgender and transgender

individuals are -- can be uncomfortable in locker rooms. So if uncomfortable is a question of harm, then we could delve into harm more specifically.

BY MR. HILDABRAND:

Q. So there might be some scenarios where it would be harmful?

MS. BROWN: Same objection.

THE WITNESS: I am not aware of specific harms in that scenario.

BY MR. HILDABRAND:

Q. Going to -- so in this section in your report, the impact of SB 228 on transgender students, from paragraphs 24 through 30, do you cite only two studies? And feel free to scroll through that to confirm.

A. You can scroll down. Keep scrolling. In this section, I see two cited studies, and additional information in the section was drafted based on my professional and personal experience.

Q. Turning to paragraph 30 on page nine, do you conclude by saying: By making it impossible for many transgender students to participate in interscholastic athletics, SB 228 denies transgender youth the opportunity to engage in positive experiences that can protect and enhance their

mental health? Is that what it says there?
A. Yes.
Q. Do you understand the law to make it impossible for all transgender students to participate in interscholastic athletics or only many transgender students?
A. I would need to review the law again specifically.
Q. Off the top of your head, you couldn't say if it's all transgender students or many transgender students?
MS. BROWN: Objection to form.
THE WITNESS: My impression is that the law restricts all transgender youth from participating in interscholastic athletics.
BY MR. HILDABRAND:
Q. Thank you. Are there other activities that could provide, besides interscholastic athletics, that students could participate at school to receive similar mental health benefits?
MS. BROWN: Objection to form.
THE WITNESS: Within a school there are many available extracurricular activities. Athletics may be a very important part of someone's experience and identity, however.

BY MR. HILDABRAND:
Q. Would it harm a cisgender girl if she did not receive All State honors because a transgender girl bumped her out of that position of earning All State honors?
MS. BROWN: Objection to form, relevance, and scope.
THE WITNESS: No, I don't believe that would harm her.
BY MR. HILDABRAND:
Q. Would it harm a natal girl or a cisgender girl if a transgender girl beat her and every other cisgender girl in the competition?
MS. BROWN: Same three objections.
THE WITNESS: No, I do not believe that's a circumstance of harm.
BY MR. HILDABRAND:
Q. Would it harm a cisgender girl if she were injured playing girls' basketball against a transgender girl?
MS. BROWN: Object to the form.
THE WITNESS: Risk of injury is present in participating in sports for people regardless of their gender identity.
/ /

BY MR. HILDABRAND:
Q. So yes or no? Do you view that as a harm?
MS. BROWN: Objection to form.
THE WITNESS: In what manner?
BY MR. HILDABRAND:
Q. Is it a harm for a cisgender girl to be injured playing girls' basketball against a transgender girl?
MS. BROWN: Same objection.
BY MR. HILDABRAND:
Q. Or is that simply a risk that comes with playing basketball?
A. I think that's a risk that comes with playing basketball.
Q. Let's turn ahead to -- you cite your current WPATH Standards of Care and we discussed those today, correct?
A. Correct.
Q. To the best of your understanding, do the current standards of care take a position on whether social transition is appropriate for prepubertal children?
A. The standards of care is a lengthy document. And from my recollection, I believe they address complexities and nuances in making decisions about

treatment planning, including a social transition.

MR. HILDABRAND: Opposing counsel, when is the end time that you have?

MS. BROWN: We're at 12 minutes and 36 seconds. Ten minutes.

MR. HILDABRAND: Ten minutes, okay. All right. Travis, can you circulate Doc R.

THE WITNESS: Do you think we can open that? Yes.

MR. HILDABRAND: And we are going to mark this as Exhibit 15.

(WHEREUPON, a document was marked as Exhibit Number 15.)

BY MR. HILDABRAND:

Q. Does this appear to be the seventh edition of the standards of care?

A. It does.

Q. Is that the current version of the standards of care?

A. It is. Standards of care eight is in development and hope to be released soon.

Q. When it's released, will you begin to consider version eight once it's released and use that in your practice?

A. I will review standards of care eight when

it's released.
Q. Let's turn for this to I think it's page 17 in the standards of care's page numbering but it's page 23 of the PDF. It's the page that says: Social transition in early childhood.
A. Okay. 23, we're there.
Q. Can you read the first paragraph, starting at the line -- let's see. Just one second. Do you see where it says: Social transitions in early childhood do occur within some families with early success? This is a controversial issue and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of competing a gender role transition during early childhood. Outcomes research with children who completed early social transition would greatly inform future clinical recommendations. Do you agree or disagree with these sentences, and are there any parts of it that you would change?
A. I agree a social transition is a complex issue and is often navigated with success.
Q. All right. Are you aware of any new chapters that will be added to the WPATH Standards of Care in version eight?

A. My impression is that the standards of care eight will include informed updates around the treatment of nonbinary and gender-diverse individuals. They may also include some updates in mental health considerations for children as well.

MR. HILDABRAND: Travis, can you circulate doc -- actually, no.

BY MR. HILDABRAND:

Q. Are you aware that there is a draft chapter on eunuchs in version eight?

MS. BROWN: Objection to form.

THE WITNESS: I was not aware of that.

BY MR. HILDABRAND:

Q. All right. Do you view eunuchism as a gender identity?

MS. BROWN: Objection to form.

THE WITNESS: I am not aware of anyone with the identity eunuchism.

BY MR. HILDABRAND:

Q. If WPATH published a standard of care chapter on eunuchism and said that eunuchism is a gender identity, would that be something that you would follow in your practice?

MS. BROWN: Objection to form.

THE WITNESS: I would need to review the

standards of care and make a decision about how that would influence my practice.
BY MR. HILDABRAND:
Q. While you're not a pediatrician or an endocrinologist, are you aware that the FDA recently placed additional warnings on the use of puberty blockers?
A. I was not aware.
MR. HILDABRAND: Travis, can you circulate Doc W. And we'll enter this as Exhibit 16.
(WHEREUPON, a document was marked as Exhibit Number 16.)
BY MR. HILDABRAND:
Q. Is this titled, Risk of Pseudotumor Therapy Added to Labeling for Gonadotrophin-Releasing Hormone Agonists? Is that the title of the document?
A. Yes.
Q. And does it say from the Food and Drug Administration?
A. I see that, yes.
Q. Would you consider FDA warnings if you were aware that are one of your patients were on puberty blockers?

MS. BROWN: Objection to form and scope.
THE WITNESS: I am not a prescriber and so do not follow closely FDA warnings.
BY MR. HILDABRAND:
Q. So you have not advised any patients about any new FDA warnings about puberty blockers; is that correct?
MS. BROWN: Same objection.
THE WITNESS: I am not aware of these until this exhibit was presented.
BY MR. HILDABRAND:
Q. Are you aware that the United Kingdom's National Health Service recently closed the Tavistock Gender Identity Disorder Clinic?
MS. BROWN: Same objection and objection to relevance.
THE WITNESS: Yes, I'm aware.
BY MR. HILDABRAND:
Q. What is your understanding of why it was closed?
MS. BROWN: Same objection.
THE WITNESS: My impression is that clinics have been closing due to significant backlash and discrimination against providers and an inability to provide care for the patients that they

serve.
BY MR. HILDABRAND:
Q. Given that clinics such as Tavistock have been closing recently, does that give you any concern or doubt about your current approach to the practice of psychology?
MS. BROWN: Same objection.
THE WITNESS: I continue to practice in a way that is consistent with best practice guidelines and the guidelines we've discussed today. Any concern in my practice would be related to fear of response in the community and harassment from others who are not affirming of a transgender or gender-diverse identity.
BY MR. HILDABRAND:
Q. Are there generally many more individuals identifying as transgender or nonbinary in the past few years than there were, say, ten years ago in your experience?
MS. BROWN: Objection to form.
THE WITNESS: In the past ten years, more individuals have come forward as identifying as gender diverse or transgender and this is true of many psychological conditions as well, that our prevalence rates have increased for depression and

autism spectrum disorder and other conditions as well.

BY MR. HILDABRAND:

Q. Just to wrap up, have you understood the questions that I have asked today and answered to the best of your ability?

A. Yes, I have or sought clarification when needed. Thank you.

MR. HILDABRAND: Of course. Thank you. That is all that I have. Thank y'all for going through this. Does Jessica, I guess, do you have any questions?

MS. JERNIGAN-JOHNSON: I do not. Thank you.

MS. BROWN: Okay. If you could give us --

MR. HILDABRAND: If you need a few minutes before coming back, that's fine with me.

MS. BROWN: No. We don't have any redirect or questions for this witness.

THE REPORTER: Mr. Hildabrand, would you like to order this transcribed?

MR. HILDABRAND: Yes. Thank you.

THE REPORTER: Ms. Brown, would you like to order a copy?

MS. BROWN: Yes, we would.

MR. HILDABRAND: Before we wrap up, did we enter the FDA risk article as an exhibit?

THE REPORTER: Document W, Exhibit 16, yes, sir.

MR. HILDABRAND: We did, okay. Great. Just wanted to make sure. All right.

MS. BROWN: And, Ms. Honeycutt, we'll read and sign instead of waiving.

FURTHER DEPONENT SAITH NOT

(Proceedings concluded at 5:57 p.m.)

E R R A T A P A G E

I, MELISSA A. CYPERSKI, Ph.D., having read the foregoing videoconference deposition, pages 1 through 257, do hereby certify said testimony is a true and accurate transcript, with the following changes (if any):

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